BHC-Behavioral Health Consultants, Inc.
9525 Katy Fwy #312 | Houston, Texas 77024
Phone (713) 463-9449 | Fax (713) 463-7181

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CONFIDENTIAL INFORMATION SHEET

This information is to help us better understand you and your situation. Please fill it out as completely as you can.
All information will be held in strict confidence.

DATE:_____

PATIENT INFORMATION:

Name: _____ Date of Birth: ____ /____/____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Mobile: _____ E-mail: _____

Preferred Method of communication: ☐Home Phone ☐Mobile ☐Email Gender: ☐Male ☐Female

Marital Status: _____ Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐I decline to specify

Race: ☐American Indian ☐Asian ☐Black/African American ☐Pacific Islander ☐White ☐I decline to specify

Preferred language: _____ Referred by: _____

Smoking Status: ☐Never Smoker ☐Former Smoker ☐Light Smoker ☐Heavy Smoker

INSURANCE INFORMATION *(skip if self pay)*:

Primary Insurance: _____ Phone: _____

Employer: _____ Policy # _____ Group # _____

Subscriber: _____ SSN: ____-___-____ Subscriber's DOB:____/___/____

Secondary Insurance: _____ Phone: _____

Employer: _____ Policy # _____ Group # _____

Subscriber: _____ SSN: ____-___-____ Subscriber's DOB:____/___/____

NEXT OF KIN / RESPONSIBLE PARTY:

Name: _____ E-mail: _____

Relationship to patient: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

1. **I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department.**
2. **AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize the release of any information regarding my condition or treatment to insurance company.**
3. **AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.**

SIGNED:_____ DATE:_____
(patient or legal guardian)

PRIMARY DOCTOR INFORMATION:

Name: _____ May we contact him/her? ☐Yes ☐No

Address:_____ City: _____ Zip: _____

Phone: _____ Fax: _____

TREATMENT HISTORY:

Have **YOU** ever had? Please check all applicable boxes:

☐Cancer
Type:_____
☐Heart Attack/Coronary
☐Artery Disease
☐Rheumatic Fever
☐Heart Failure
☐High blood pressure
☐High cholesterol
☐Stroke
☐Diabetes
☐Gallstones
☐Liver Disease
☐Hepatitis/Jaundice
☐Ulcer Disease
☐Heartburn/Reflux
☐Asthma
☐Seizures

☐Emphysema
☐Pneumonia
☐Tuberculosis
☐Positive TB Skin Test
☐Osteoporosis
☐Arthritis
☐Gout
☐Frequent Bladder Infection
☐Kidney Stone
☐Kidney Disease
☐Polio
☐Chicken Pox
☐Infectious Mono
☐Anemia
☐Frequent Sinus Infection

☐Glaucomo
☐Thyroid Trouble
☐Hives
☐Depression
☐Head Injury
☐Broken Bones
☐Blood Transfusions
☐Sexually Transmitted Diseases:Herpes. HIV
☐Gonorrhea
☐Chlamydia
☐Syphilis
☐Intravenous drug abuse
☐Needle Injury
☐Mumps
☐Migraines

☐Prostate Enlargement
☐Cystic Fibrosis
☐Malaria
☐Other:
_____
_____

IMMUNIZATIONS:
☐Measles, Mumps and Rubella Vaccine
☐Chicken pox vaccine
☐Hepatitis B vaccine
☐Influenza vaccine
☐Pneumococcal vaccine
☐Tetanus booster

Past Surgical History. Please check all applicable boxes and enter year:

☐Eyes (Laser or Vision Corrected) _____
☐Eyes (Cataract/Glaucoma _____
☐Ears _____
☐Sinus/Nasal Septum _____
☐Tonsils/Adenoid _____
☐Thyroid _____
☐Heart _____
☐Stomach _____
☐Varicose Veins _____

☐Gall Bladder _____
☐Appendix _____
☐Intestine/Colon _____
☐Hemorrhoids _____
☐Hernia _____
☐Breast _____
☐Uterus/Hysterectomy _____
☐Ovaries _____
☐Spinal Surgery/Neck _____
☐Prostate _____

☐Spinal Surgery/Back _____
☐Orthopedic (Hips/Knee/ Shoulder/Feet/Hands) _____
☐C-section _____
☐Vasectomy _____
☐Tubal Ligation _____
☐ Other:
_____ _____
_____ _____

Has anyone in your **FAMILY** ever had? Please check all applicable boxes:

☐Cancer
Type: _____
☐Diabetes
☐Cardiac Dysrythmia
☐Congestive Heart Failure
☐Cornary Artery Disease
☐Valvular heart Disease
☐High Blood Pressure
☐High Cholesterol
☐Stroke
☐Kidney stones
☐Kidney disease

☐Dialysis
☐Chronic lung Disease
☐Tuberculosis
☐Rheumatoid Arthritis
☐Thyroid trouble
☐Osteoporosis
☐Cystic Fibrosis
☐Asthma
☐Peptic Ulcer
☐Gallstones

☐Crohn's / colitis
☐Alzheimer's
☐Alcoholism
☐Bleeding tendency
☐Anemia
☐Gout
☐Depression
☐Mental illness
☐Seizures
☐Migraine headaches

Allergies (List all medication and drug allergies):

_____

_____

Medications (List all medications prescribed and taken for the last 12 months):

Name	Dosage	Schedule

Do you **CURRENTLY** feel or have? Please check all applicable boxes:

GENERAL
☐Fatigue
☐Fever
☐Weight Gain >10 lbs
☐Weight Loss >10 lbs

SKIN
☐Nail Changes
☐New Lesions

HEENT
☐Double Vision
☐Eye Pain
☐Eye Redness
☐Decreased Hearing
☐Earache
☐Ear Ringing
☐Nose Bleeds
☐Dry Mouth
☐Hoarseness
☐Oral Ulcers
☐Sore Throat

NECK
☐Neck Pain
☐Swollen Glands

BREAST
☐Breast Mass
☐Breast Pain
☐Nipple Discharge
☐Skin Changes

RESPIRATORY
☐Chronic Cough
☐Decreased Exercise Tolerance
☐Difficulty Breathing
☐Coughing Up Blood
☐Sputum Production
☐Wheezing

CARDIOVASCULAR
☐Chest Pain
☐Leg Pains with walking
☐Leg Swelling
☐Night Awakening due to trouble breathing
☐Palpitations
☐Shortness of Breath

GASTROINTESTINAL
☐Abdominal Pain
☐Change in Bowel Habits
☐Constipation
☐Diarrhea
☐Nausea
☐Vomiting
☐Rectal Bleeding
☐Trouble Swallowing

URINARY
☐Increased Frequency
☐Blood in Urine
☐Loss of Bladder Control
☐Urinary Retention
☐Urethral Discharge
☐Incontinence

MUSCULOSKELITAL
☐Muscle pain
☐Stiffness
☐Back pain
☐Joint pain
☐Redness of joints
☐Swelling of joints

NEUROLOGIC
☐Loss of Bowel Control
☐Dizziness/Vertigo
☐Fainting
☐Seizures
☐Numbness
☐Tingling
☐Tremor

PSYCHIATRIC
☐Anxiety
☐Depression
☐Nervousness
☐Stress
☐Memory Loss

ENDOCRINE
☐Appetite Changes
☐Cold Intolerance
☐Increased Thirst
☐Increase Urination
☐Hair Changes
☐Sexual dysfunction
☐Sweating

HEMATOLOGY
☐Easy Bruising
☐Enlarged Lymph Nodes
☐Prolonged Bleeding

I certify the information provided is correct and I authorize services to be provided to the above named patient.

_____ _____

Patient /Legal Guardian Signature **Date**

GENERAL INFORMATION AND OFFICE POLICIES (Office Copy)

Appointment and Service Fee

Initial Evaluation may last from 45 mins to 60 mins. Follow up treatment and medication management last about 10-15 minutes.

You will be charged **$60.00** for **no shows** and **late cancellations**. Appointments must be cancelled at least **24 hours** prior to the reserved time if you are unable to keep it. You may call the office during normal business hours. A 24 hour answering service is also available 7 days a week to take messages, for your convenience.

We accept all forms of payment for your convenience**.** Payment is expected at the time of each visit unless prior arrangement has been made. Penalty for returned check is **$35.00.** Patient/Responsible party is ultimately responsible for any amount not covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, the client and provider can negotiate a payment schedule.

I understand and accept the policies concerning both the cancellation of appointments and payment for services. Furthermore I agree that successive missed appointment is subject to termination of our doctor-patient relationship.

_____ _____

Patient /Responsible Party Signature Date

Medication Refills between Appointments

All refills will be handled during your scheduled appointment. Additional refills will be given upon the discretion of the doctor. If a medication refill becomes necessary outside your appointment time, please have your pharmacy contact us. Optionally, you may leave a message on our Prescription Line by calling 713-464-2595. When leaving a message, provide the pharmacy phone number, medication name, dosage and directions on how you are taking your medication. Schedule II medications are filled on a monthly basis. Patient who are stable on these medications are not required to schedule monthly appointments. However you must call the prescription line to get a new prescription in between appointments. You must schedule an appointment on the third month to avoid denial of request. We appreciate your cooperation in keeping track of your medication supply. You are ultimately responsible in making sure that you do not run out of medication. Allow at least 72 hours processing time. **There is a $10 fee per prescription refill requests of Schedule II medications between appointments. *(Fee does not apply to Medicare and Medicaid patients)* Refills will not be authorized if you missed or cancelled your appointment.**

I understand and accept the policy concerning medication refills between appointments

_____ _____

Patient /Responsible Party Signature Date

Confidentiality

Your patient records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent. Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by the patient. In an emergency situation when you, the patient, are at imminent risk of death or serious medical consequence, your provider may release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of abuse. Be advised that email and mobile phone conversations are not secure or guaranteed of privacy because they can be intercepted, hence confidentiality may be potentially compromised.

I understand and accept the policy concerning my confidentiality

_____ _____

Patient /Responsible Party Signature Date

Letters/Medical Reports/Correspondence/Disability Forms

Any reports, letters, forms or correspondences that are deemed not medically necessary for your treatment are additional tasks to the doctor. Therefore, we charge for these additional tasks. Please allow 7 to 10 days for completion of your requests after we have all the appropriate releases and/or information to complete the forms.

Below is some general information about medical correspondence.

We must have a signed release from the patient to release information to anyone else. This includes family members, other doctors, insurance companies, and employers. Please make sure you sign our release form at the time of your request. We must have clear instructions as to what method the information will be conveyed to the other party, i.e. fax, mail, telephone. We need complete fax numbers, phone numbers and/or addresses. **The cost of reproducing records is $1.00 per page. The charge for a letter and other request is $25.**

I understand and accept the above office policy

_____ _____

Patient /Responsible Party Signature Date

PATIENT RECEIPT OF PRIVACY NOTICE

(Office Copy)

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we shar
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

By signing below, I acknowledge receiving a copy of the "Privacy Notice" of BHC-Behavioral Health Consultants, Inc. describing my right to privacy of my protected health information (PHI) under the Federal HIPAA Privacy Law, as follows:

- **How my PHI may be used and disclosed,**
- **My privacy rights regarding my PHI,**
- **The medical practice's obligations concerning the use and disclosure of my PHI.**

Patient Name/Guardian _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this notice but was unable to do so as documented below:

Date:	Initials:	Reason:

BHC's No Show Pre-Authorized Charge Form

I authorize BHC-Behavioral Health Consultants, Inc. to keep my signature on file and to charge my Credit Card listed below for:

☐ The one time amount of $ **60.00 in the event that I fail to cancel my scheduled appointment and failed to provide 24 hours notice.**

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Customer Name:_____

Cardholder Name:_____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Account Number:_____

Expiration Date:_____ Card Verification Number: _____

Cardholder Signature: X_____ Date: _____

USE OF PRE-AUTHORIZED CHARGE FORMS

This form is a pre-authorization to charge credit card payments to your customers. You must still complete the actual credit card charges, including getting an authorization for each transaction.

The information on this form is to be used to fill out your charge slips, as is authorized by the cardholder for payment of future or ongoing visits.

1. The name of the service provider-your practice or business (as it appears on your card imprinter) must be filled in the top line.
2. The cardholder must choose one of the three payment schedules indicated by each of the three boxes:
    i) Charges not paid by insurance, not to exceed a designated amount, for either the current visit, or for all visits within a year.
    ii) Recurring charges of a specific amount, to be charged on a scheduled basis between two designated dates.
    iii) A total fee, of a designated amount to be charged to the customer's card one time.
3. Personal information must be completed by the provider, stating the customer's name, cardholder's name, card type, account number and expiration date. Please be careful to note that the cardholder's card expiration date does not extend beyond the "ending date" for any recurring charges.
4. The cardholder must sign and date the form at the bottom.
5. The cardholder receives the top copy, and the bottom two copies are retained by the service provider. (If there is any discrepancy regarding the charges, the provider has the second copy to supply to the cardholder's bank.)
6. The form is valid for use for one year, or until the cardholder cancels authorization through written notice to the service provider.

PATIENT COPY OF GENERAL INFORMATION AND OFFICE POLICIES
(Please keep for your records)

Appointment and Service Fee

Initial Evaluation may last from 45 mins to 60 mins. Follow up treatment and medication management last about 10-15 minutes.

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We accept all forms of payment for your convenience**.** Payment is expected at the time of each visit unless prior arrangement has been made. Penalty for returned check is **$35.00.** Patient/Responsible party is ultimately responsible for any amount not covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, the client and provider can negotiate a payment schedule.

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Patient /Responsible Party Signature Date

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Patient /Responsible Party Signature Date

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I understand and accept the above office policy

_____ _____

Patient /Responsible Party Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.