FAMILY PSYCHIATRY OF THE WOODLANDS, P.A.
PATIENT INFORMATION

PATIENT NAME_____BIRTHDATE_____
First Middle Initial Last

PATIENT SEX: _____Male _____ Female PATIENT SSN_____

HOME ADDRESS_____CITY/STATE_____ZIP CODE_____
HOME PHONE # ( ) _____
ALTERNATE PHONE # WHERE WE MAY REACH YOU ( ) _____

RESPONSIBLE PARTY NAME _____ REL TO PT _____
PHONE # ( ) _____ ADDRESS _____
CITY/STATE_____ ZIP CODE_____
EMPLOYER _____ PHONE # ( ) _____

PRIMARY INS. _____ INSURED NAME _____
PHONE #_____ REL TO PT_____ BIRTHDATE_____
SOCIAL SECURITY NO._____ GROUP/PLAN_____
EMPLOYER NAME, ADDRESS, PHONE # _____

SECONDARY INS. _____ INSURED NAME _____
PHONE # _____

A COPY OF YOUR DRIVERS LICENSE and INSURANCE CARD IS NEEDED
PAYMENT OF SERVICES IS HANDLED PRIOR TO YOUR SESSION

All reasonable requests for confidential handling of your health information by alternative means will be granted:

- May we leave a message on your home answering machine? Y___ N ____
- Do you have an alternate phone number we may use? Y___ N ____ Phone # _____
- Emergency Contact Name _____ relationship_____ & Phone Number _____
- May we share information regarding appointments or billing inquiries only with your spouse or an immediate family member? Y___ N___ Names: _____

- **If the patient is a Minor, are biological parents: married ____ never married____ divorced ____. Minor Child Treatment Information may be shared with Non-Custodial Parent (if not specified otherwise in the court order) Y__ N __**
  Non-Custodial Parent Name: _____

Please complete the following section *only* if you want communications regarding your health care information or billing sent to an **alternate address** other than your residence.

_____
(Street Address)

_____ _____ _____
(City) (State) (Zip Code)

Family Psychiatry of The Woodlands, P.A.
Effective 7/16/08

We are committed to providing our patients with the best possible care and we are pleased to discuss our professional services with you at any time. Your clear understanding of our Office Procedures and Financial Policies is very important. All patients must complete our "Patient Information Form" before seeing the Professional

Payment of services is handled prior to your session. Your insurance company mandates you must pay your co-payment at the time of service. If you cannot pay, you may be asked to reschedule.

We accept cash, checks, Visa, MasterCard, Discover, American Express, and Debit. If a check is returned for insufficient funds, we will not accept another check from the patient. Payment will have to be cash, credit or debit. There is a $25 returned check fee. We do not accept temporary or post-dated checks if you are a new patient.

We charge for missed/cancelled appointment, *unless* cancelled at least 24 hours in advance. Our policy is to charge $50.00 for missed/canceled appointments. Please do not rely on appointment reminder calls, as this is a courtesy. Having 3 or more no shows or cancellation of appointments can result in termination of treatment. Please help us serve you better by keeping scheduled appointments. NOTE: You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you feel you were charged in error, please discuss this matter with our office manger.

We charge a service fee for certain form and/or letters that must be completed for a patient. Full one-month prescriptions will not be released without payment. We also require Self-Addressed, Stamped Envelopes for mailing prescriptions.

If you choose this office will provide you with a completed receipt showing charges, payments, which you may file with your insurance company.

Childcare is not provided for children. Please do not leave children unattended in the reception area.

All Medicaid patients must present the current, monthly Medicaid Letter (not an Insurance card) **at every visit as mandated by Medicaid or the visit will be rescheduled without exception.**

In the event of a Divorce, we must have a copy of the Divorce Decree signed by a judge. The decree must state which parent has Managing Conservatory privileges for the minor child.

REGARDING INSURANCE ASSIGNMENT

We will only file claims with insurance companies we are contracted with. In order to achieve this, we must have all current insurance information on file.

If there are any changes in your insurance coverage, you must notify our Business Office 5 days prior to your next appointment or the visit will be self-pay or rescheduled.

The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company, is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization, but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is any estimate only. You are ultimately responsible for any and all balances on your account.

Should you have any problems regarding your account or about the filing of claims, fees, or billing records, please do not hesitate to ask our Business Office Staff.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF FAMILY PSYCHIATRY OF THE WOODLANDS.

_____ _____

Signature **Date**

FAMILY PSYCHIATRY OF THE WOODLANDS, P.A.

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT:

___ ITEM 1 – FEMALE PATIENTS
Initial If taking medication I agree to notify ***Family Psychiatry of The Woodlands*** in the event that I am planning to become pregnant, or I become pregnant so that I may discuss the risks/benefits of medication.

___ ITEM 2 – ALCOHOL/DRUGS/HERBAL SUPPLEMENTS
Initial It is recommended not to use alcohol/drugs or herbal supplements in combination with prescription psychiatric medication and I agree to notify ***Family Psychiatry of The Woodlands*** if this is a concern.

___ ITEM 3 – MEDICATION REFILLS
Initial Medication is prescribed to last until your next appointment. You will need to make an appointment and be seen when medication refills are required.

___ ITEM 4 – LETTERS AND/OR FORMS
Initial There will be a charge for any forms and/or letters that must be completed in this office by any practitioner or office staff.

___ ITEM 5 – THERAPY SESSIONS
Initial Therapy sessions are scheduled for 30 or 45 minutes. In order that you receive your entire session, please be prompt for you appointment.

___ ITEM 6 – CONFIDENTIALITY
Initial All information is guarded by strict confidentiality. We require your written consent in order to release / obtain information.

___ ITEM 7 – CONSENT FOR TREATMENT – CONSENT MUST BE SIGNED PRIOR TO THE START OF YOUR APPOINTMENT
Initial

I hereby give consent for myself or the above named patient to be treated/tested by Family Psychiatry of The Woodlands, P.A. If the above named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court documents, that I have the legal right to request treatment for the above named minor. If you are **15-17 years of age,** you must co-sign. If you are **18 years of age,** you must sign yourself and are allowed the right to choose whether you wish anyone/parents to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co-joint therapy. A parent/guardian may not come in for an appointment without the patient. **The patient must be present at every visit. Patients under 18 years of age will only be seen with a parent or guardian present.**

___ ITEM 8 – TERMINATION OF TREATMENT
Initial Assault or verbally threatening behavior towards staff, other patients, or physical property of Family Psychiatry of The Woodlands, P.A. will be cause to terminate treatment and be held responsible for damages. Firearms and other weapons are prohibited, with exception for an officer of the law.

___ ITEM 9 – CANCELLATIONS
Initial **Cancellations must be made 24 HOURS before your session.** Your session time is reserved for you and you will be charged a **$50.00 no-show fee** for late cancellations or missed appointments. **Our office policy allows three no-show fees before terminating services.**

___ ITEM 10 – OUTSIDE LAB OR OTHER DIAGNOSTIC TESTS

Initial We do not get authorization from your insurance for any ordered tests that are performed outside our office. We suggest you contact your insurance carrier to insure that you will be reimbursed for the charges and are aware of your benefit coverage.

___ ITEM 11 – MANAGED CARE PLANS

Initial This practice has contracted with several managed care plans and will be handled according to our agreement with them. All co-payments must be paid at time of service. It is your responsibility to be aware of coverage variables, such as preventive health care, deductibles, etc., and to pay for services not covered by your insurance company. Following notification for the insurance company, any denied amounts would be due immediately, upon being notified by our office.

___ ITEM 12 – ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

Initial I hereby authorize my insurance carrier to pay benefits directly to Family Psychiatry of The Woodlands, P.A. for services provided to myself or my insured dependent, realizing I am responsible to pay for all services provided. I hereby authorize the release of pertinent information required by my insurance carrier to process insurance claims for payment to Family Psychiatry of The Woodlands, P.A.

___ ITEM 13 – PAGING SYSTEM

Initial There is a 24-hr paging system for emergency situations. There is a $45.00 charge for non-emergent after hour calls.

___ ITEM 14 – EMERGENCY SERVICES

Initial I agree to contact ***Family Psychiatry of The Woodlands*** or 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

___ ITEM 15 – FINANCIAL POLICY

Initial I acknowledge that I have read and understand the financial policies of this office.

___ ITEM 16 – NOTICE OF PRIVACY PRACTICES

Initial I acknowledge that I have received a copy of the Notice of Privacy Practices of this office effective April 15th, 2003.

___ ITEM 17 – BILLING INQUIRY

Initial If you have billing questions, we will be pleased to help you. Contact our billing office at 281-363-4693.

Items 1 – 17, initialed by me, indicate my understanding of legal Terms and Conditions in connection with the treatment of patient.

_____	_____	_____
Patient Signature	Initials	Date
_____	_____	_____
Parent/Guardian Signature	Initials	Date

Family Psychiatry of The Woodlands, P.A.
8701 New Trails Drive #150
The Woodlands, Texas 77381

Clients' Rights

1. **You have all the rights of any other resident of the State of Texas and the United States of America.**
2. You have the right to not be discriminated based on age, race, ethnicity, gender, sexual orientation, religion, national origin, physical or mental disability, or other attributes.
3. **You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.**
4. You have the right to be free from abuse, neglect, and exploitation.
5. **You have the right to be treated with dignity and respect.**
6. You have the right to be told about the treatment you will be given, the risks, side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.
7. **You have the right to accept or refuse treatment after receiving this explanation.**
8. You have a right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
9. **You have the right to know the qualifications of the staff responsible for your treatment.**
10. You have the right to refuse to take part in research without affecting your regular care.
11. **You have the right not to be given medication you don't need, or too much medication.**
12. You have the right to have information about you kept private and to be told about the times when the information can be released without you permission.
13. **Unless otherwise provided by law, you have the right to withdraw at any time you permission for something you agreed to earlier.**
14. You have the right to make a compliant and receive a fair response from this facility within a reasonable amount of time.
15. **You have the right to contact and consult with counsel at your expense.**
16. You have the right to select practitioners of your choice at your expense.
17. **You have the right to choose whether your parents may be present and participate in your treatment if you are at least 18 years of age.**

I acknowledge having read and understood the above client rights.

_____	_____
Signature of Patient	**Date**
_____	_____
Signature of Parent or Legal Representative	**Date**
_____	_____
Signature of Witness	**Date**

Initial Evaluation & Follow-up Medication Visits

Welcome to our practice. Please take a moment to read the following information regarding our office procedures.

On your **First Visit:**

- A clinician will obtain a detailed medical and psychiatric history; taking up to 40 minutes.
- In a few cases, when the diagnosis is not clear from history, he may need additional testing before making treatment recommendations.
- The clinician then explains the diagnosis, treatment recommendations and answers any questions you may have.
- The clinician will also direct you to check out to schedule a follow-up appointment. It is wise to schedule that appointment while in the office, if at all possible.
- The **clinician** who took your history is your **primary contact person** in this office.

For follow-up **Medication Management Visits:**

- Patients routinely are scheduled with the clinician for follow-up medication management visits to assess your treatment response and monitor for side effects. The clinician will meet with you; obtain information regarding your response to the treatment plan.
- For your safety, medication changes are generally not made over the phone. However, if you feel you are having an adverse reaction, please call your primary contact person immediately.
- You will typically see the clinician for return visits. These visits are scheduled on the half hour through out the day. For sessions that extend past the 15 minutes, an additional charge will be applied.

If you need **Psychotherapy:**

- Psychiatrist, Nurse Practitioners, and Physician Assistants do not see patients for psychotherapy.
- The clinician will refer you to a therapist in our office, if possible, on your insurance plan.

_____ I have read the above policy and understand it.
Initials

Family Psychiatry of The Woodlands
8701 New Trails Drive, Ste. 150
The Woodlands, Texas 77381
Phone: 281-367-1015 Fax: 281-367-1966

Effective Date: April 14, 2003

If you have any questions about this notice, please contact HIPAA grievance officer 281-367-1015. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a compliant.

WHO WILL FOLLOW THIS NOTICE
Any physician or health care professional authorized to enter information into your chart. All departments of the practice. All employees, staff and other office personnel. All these individuals. In addition we may share with each other and third party specialists for treatment, payment, and purposes described in this notice.

WE ARE REQUIRED BY LAW TO:
Make sure that medical information that identifies you is kept private. Give you notice of our legal duties. Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU
Treatment- We may use medical information about you to provide you with medical treatment services. We may disclose medical information about you to people outside the office who may be involved in your care. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

Payment- We may use and disclose medical information about you so that treatment and services you receive at our office may be billed to and payment collected from you, and insurance company or a third party.

Appointment Reminders- We may use and disclose medical information to contact you as a reminder that you have an appointment for medical services at the office. We do notify our patients by telephone.

As Required By Law- We will disclose medical information about you when required to do so by federal, state, or local law.

SPECIAL SITUATIONS
Health Oversight Activities- We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes- If you are involved in a lawsuit or a dispute we may disclose medical information about you in response to a court order. We may also disclose information about you in response to a subpoena.

Coroners, Medical Examiners, and Funeral Directors- We may release medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU
Right to Inspect and Copy- If you request a copy of the information we may deny your request due to mental health liabilities.

Right to Amend- If you feel that medical information we have about you is incorrect or incomplete you may as us to amend the information. In addition you must provide a reason that supports your request. We may deny your request for an amendment but your request will be put into your permanent file as you requested it be changed.

Right to Request Restrictions- You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment, or health care operations.

Right to paper copy of this notice- You have the right to a paper copy of this notice. To obtain a paper copy of this notice please contact us at Family Psychiatry of The Woodlands HIPAA Privacy Officer @ 4840 West Panther Creek Ste 210 The Woodlands, Texas 77381

CHANGES TO THIS NOTICE
We reserve the right to change this notice.

COMPLIANTS
If you believe your privacy rights have been. You can file a compliant with our Grievance Officer at 281-367-1015.

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this notice will only be made with your written permission. You may revoke that permission in writing at any time; if you do we will no longer use or disclose medical information. Understand that we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Patient & Family History – New Patients

Presenting Problem:
Please state the reason and/or symptoms that brought you here today:
_____
_____
_____
Are there any significant events associated with the above reason? Yes____ No ____
If yes, please provide more information: _____
_____

Check all symptoms you have been experiencing:

( ) recent weight gain How much? _____
( ) recent weight loss How much? _____
( ) difficulty falling asleep (insomnia) ( ) Excessive sleeping ( ) Fatigue
( ) Middle of the night awakening ( ) Decreased energy ( ) Lack of motivation
( ) Restlessness or agitation ( ) Decreased appetite ( ) Increased appetite
( ) Frequent mood swings ( ) Frequent anger ( ) Irritability
( ) Complaints of despair, hopelessness, worthlessness ( ) Inattention
( ) Inability to experience pleasure ( ) Inability to express feelings
( ) Withdrawal from others ( ) Difficulty concentrating
( ) Loss of Libido ( ) Loss of thought process
( ) Difficult focusing resulting in unfinished task

Are you presently having **thoughts of suicide?** Yes____ No____
If yes, please provide more information: _____
_____
_____
Have you ever made a **suicide attempt?** Yes____ No____
If yes, Please provide more information. (When, how) _____
_____
_____

Patient Medical History:

Have you ever had **psychiatric treatment?** Yes____ No____
If yes, please describe: Date: _____ Provider:_____
Reason:_____
_____

History of Substance Use and/or Abuse:

Have you ever used **drugs?** ( ) no ( ) yes

Substance	Age began	Frequency/amount	Last time used
1.			
2.			
3.			

Have you ever been in **treatment** (hospital or outpatient) **for drug** and or **alcohol abuse?** Yes____ No____ If yes, please describe, providing date, provider and type of treatment:
_____
_____

Do you use any **tobacco product**? Yes____ No____

Allergies to medications? _____
_____

History of any of the following conditions? Yes____ (Check below), None _____

- ☐ Meningitis
- ☐ Hepatitis
- ☐ Mononucleosis
- ☐ Renal KIDNEY problems
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood pressure
- ☐ Low Blood pressure
- ☐ Rheumatic fever
- ☐ Seizures (other than febrile)
- ☐ Serious head injury. With or without loss of consciousness? (circle)
- ☐ Other: _____

Surgery: Yes____(Check below), None ____

- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Gallbladder removal (Cholecystectomy)
- ☐ Hysterectomy (partial or complete?)
- ☐ Other: (specify)_____

_____

Current Medical Conditions (diabetes, seasonal allergies, high blood pressure, etc.):
_____
_____

Females: Last menstrual period:_____
Are you currently pregnant? Yes_____ No _____
Breastfeeding? Yes_____ No_____

Developmental history **(Children and adolescents ONLY):**

- Was the pregnancy _____ planned or _____ unplanned?
- Was it full-term? ____Yes ____ No
- Normal pregnancy? Yes _____ No(explain) _____
- How did the mother feel about this pregnancy? _____
- How did the father feel? _____
- Were any alcohols, drugs, or medications used during pregnancy? ____ Yes ____ No
- If yes, please describe:
- Were there any problems with the pregnancy? _____

- Delivery: Normal vaginal ____ C-Section _____
- Was the baby _____ breast fed _____ bottle fed _____ both?
- Who was the primary caretaker for the child? _____
- Estimate when your child first:

Smiled	_____	Sat up on own	_____
Crawled	_____	Stood	_____
Walked	_____	Ran	_____
Said first word	_____	Said phrases	_____
Fed self	_____	Dressed self	_____
Toilet trained	_____		

Current Medications: (Example: Prozac 20mg one a day. Include **all** meds, not just psychiatric ones. Also include any over-the-counter meds, vitamins, etc.)

Medication Name	Dose	How Often	Reason/Treatment of

Family Medical History: check & list – i.e. Mother (M), Father (F), Paternal Grandmother (PGM), etc.)

- ☐ Diabetes_____
- ☐ Thyroid disorder_____
- ☐ Heart attack or heart disease_____
- ☐ High blood pressure_____
- ☐ Stroke_____
- ☐ Alzheimer's Disease_____
- ☐ Parkinson's Disease_____
- ☐ Migraine Headaches_____
- ☐ Other (list):_____

Family Psychiatric History: (check & list as above)

- ☐ Depression_____
- ☐ Bipolar Disorder (Manic Depression)_____
- ☐ Schizophrenia_____
- ☐ Alcoholism_____

Family Psychiatric History Con't: (check & list as above)

- ☐ Drug abuse or dependency_____
- ☐ ADHD or ADD_____
- ☐ Obsessive Compulsive Disorder_____
- ☐ Anxiety or Panic symptoms_____
- ☐ Other (list)_____

Religious preference: _____

Are there any cultural issues or religious beliefs that might affect your treatment?
No____Yes (explain) _____
_____

Current Marital Status: Married____, Divorced____, Separated_____, Single____, Widowed____,
Number of Marriages____, **Non-applicable (child)____**
Years in current marriage? _____
Is spouse supportive? Yes____ No (explain)_____

Children? Yes____ How many? _____

Child's Name	Age	Biological, step, adopted, foster
1.		
2.		
3.		

Describe who lives in household: (e.g. husband, wife, children, mother, father, siblings, pets,etc.)_____
_____
_____

Education: (Check all that apply.)

- ☐ Currently in _____ grade at _____ (name of school) in _____(school district).
- ☐ Dropped out of school in the _____grade.
- ☐ High School graduate Major/Skill learned?_____
- ☐ GED
- ☐ Some college Major/Skill learned?_____
- ☐ 2 year degree (college) Major/Skill learned?_____
- ☐ 4 year degree (college) Major/Skill learned?_____
- ☐ Graduate degree Major/Skill learned?_____
- ☐ Other _____

Work History of Patient: (Current job, how long at job, do you enjoy your work, work stressors?)
_____
_____
_____

Family of origin: Grew up in intact family (i.e. Mother & father stayed married.)

- ☐ Parents divorced when patient _____years old. Patient lived with: mother____ father____.
- ☐ History of physical abuse at hands of _____.
- ☐ History of sexual abuse at hands of _____.
- ☐ History of emotional abuse at hands of _____.
- ☐ Siblings: brothers_____ sisters_____ (how many?)
- ☐ Close family relationships.
- ☐ Not very close family relationships.

Completed by: _____ (Patient or Parent/Guardian)
(Signature)

Reviewed by: _____

Patient Name: _____ Patient #:_____ Date: _____12

Family Psychiatry of The Woodlands, P.A.
8701 New Trails Drive #150
The Woodlands, TX 77381

PRIMARY CARE PHYSICIAN CONTACT FORM

I, (patient name)_____,SSN_____, DOB_____, authorize Family Psychiatry of The Woodlands, for the purpose of case consultation/continuity of care, to release & receive information re: my evaluation & treatment to:

Primary Care Physician: _____
Address:_____
Phone # _____ Fax #_____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent shall expire on:_____.

Patient Signature:_____ Witness Signature:_____

Parent or Guardian Signature: _____ Date:_____

***********DO NOT WRITE BELOW THIS POINT***********

This patient is currently under my care for: _____Evaluation only
_____Medication management
_____Detoxification from _____
_____Other_____

This patient has been placed on the following medication(s)/dosage(s):
_____
_____
_____
_____

This office has ordered the following labs/tests (circled):

CBC	Depakote level	Lithium level	Serum pregnancy
Chem 20	Desipramine level	Tegretol level	Urine pregnancy
Liver function	Doxepin level	Urinalysis	Urine drug screen
Thyroid profile	Imipramine level EKG	Other _____	

I have requested that this patient consult you re: _____
_____

I have also referred this patient to: _____
_____

If you have any questions or concerns regarding my treatment of this patient, please feel free to contact my office.

Treating practitioner: **___ Marshall B. Lucas, M.D.**
___ Cynthia DeVos, M.D.
___ Wayne Keller, M.D.
___ Mark Lejsek, APN
___ Sharon O'Konski, PMH-NP, PC
___ Brenda Schiavone, MSN, RN, PMHCNS
___ Wanda Hilliard, MBA, RN
___ Glenn Humphress, M.S., PA-C

mailed to PCP by _____ Date___/___/_____

Patient Guidelines and Consent for Use of E-mail Communications
Family Psychiatry of The Woodlands

To better serve our patients, this office has established a website for some forms of communication. Our website will allow you to send messages to the appropriate staff member in regards to scheduling, practitioner questions, billing issues, and medication refills. Please remember, however, that this form of communication is **not appropriate for use in an emergency.** The turnaround time for routine patient communications is within twenty-four hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

Types of communication that are appropriate for e-mail include:

- scheduling inquiries
- non-urgent medical advice
- billing or insurance questions
- test and lab results
- home health monitoring reports
- prescription refill requests (per practice policy)
- educational materials

When sending e-mail, please put the subject of your message in the subject line so we can process it more efficiently. Some forms of communication (e.g., HIV, mental health, work-related injuries and disability) are not appropriate for e-mail. Also, be sure to put your name, date of birth, and return telephone number in the body of the message. We also ask that you acknowledge receipt of e-mails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above e-mail policy.

_____
Patient signature

_____
Date

_____
Witness (optional)