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 # ( ) ______________________

A COPY OF YOUR DRIVERS LICENSE 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. 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. 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.

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.

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 – 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 2 – 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 3 – CONFIDENTIALITY**
Initial All information is guarded by strict confidentiality. We require your written consent in order to release / obtain information.

___ **ITEM 4 – 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 5 – 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 6 – 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 7 – 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 8 – 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 9 – FINANCIAL POLICY**
Initial I acknowledge that I have read and understand the financial policies of this office.

___ **ITEM 10 – 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 11 – 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 – 11, 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**

Family Psychiatry of The Woodlands
8701 New Trails Dr., 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 @ 8701 New Trails Dr. # 150 The Woodlands, TX 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.

Family Psychiatry of The Woodlands
Brief Sleep-Wake Questionnaire

Common symptoms of sleep-wake problems are listed below. Pease read each item and respond by circling either true ("T") or false ("F").

1. I have been told that I snore.	T	F
2. I take naps more than twice per week.	T	F
3. I have a history of high blood pressure.	T	F
4. I have been told that I stop breathing during sleep.	T	F
5. It takes me a long time to fall asleep.	T	F
6. It's hard to go back to sleep if I awaken at night.	T	F
7. I awaken too early in the morning.	T	F
8. I usually feel sleepy during the day.	T	F
9. It's hard to sleep without sleeping pills.	T	F
10. My dreams bother me.	T	F
11. I have been told that I jerk my legs when sleeping.	T	F
12. I do not feel rested after awakening in the morning.	T	F
13. I become irritable if I don't sleep well.	T	F
14. I have been told that I walk in my sleep.	T	F
15. I often have trouble awakening in the morning.	T	F

6/2011

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)

Client Information and Agreement
Destiny K. Lucas, M.A.C., LPC
Licensed Professional Counselor (LPC)

I am pleased you have chosen me as you counselor. This document is designed to inform you about my background and to insure that you understand our professional relationship.

I am licensed as a Professional Counselor by the Texas State Board of Examiners for Licensed Professional Counselors. Only licensed mental health professional may provide counseling services in this state.

I hold a Master's (M.A.C.) degree in counseling from Saint Edwards University. I received a Bachelor's (B.S.) degree in psychology from Sam Houston State University.

I have been a counselor since 2004. I provide services for clients in my private practice who I believe have the capacity to resolve their own problems with my assistance. A counseling relationship between a Profession Counselor and client is a professional relationship in which the Professional Counselor assists the client in exploring and resolving difficult life issues. I believe that as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. Self-awareness and self-acceptance are goals that sometimes take a long time to achieve. While some clients may need only a few counseling session to fell complete, others may require months or even years of counseling. Clients are in complete control and may end our counseling relationship at any point and I will be supportive of that decision. If counseling is successful, clients should feel that they are able to face life's challenges in the future without my support or intervention.

My counseling services are limited to the scheduled sessions we have together. In the event you feel your mental health requires emergency attention or if you have an emotional crisis, you should report to the emergency room of a local hospital and request mental health services.

Although our sessions will be very intimate, it is important for you to realize that we have a professional, rather than personal, relationship. Our contact will be limited to the paid session you have with me. Please do not invite me to social gatherings, offer gifts, or ask me to relate to you in any way outside our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling experience. However, it is important for you to remember that you are experiencing me only in my professional role.

My counseling practice is limited to adolescents and adults and includes personal, couples, marriage, and family therapy.

I will keep confidential anything you say to me with the following general exceptions: you direct me to tell someone else, I determine you are a danger to yourself or others, or I am ordered by a court to disclose information.

In the event you are dissatisfied with my services for any reason, please let me know. If I am not able to resolve your concerns, you may report your complaint to the State of Texas Licensed Professional Counselors Board of Examiners, (P.O. Box 141369
Austin, Texas 78714-1369, 1-800-942-5540). I hold license # 20309.

In return for a fee of $150.00 for initial session, and $130.00 thereafter, I agree to provide counseling services for you. Sessions are 30 or 45 minutes in duration. It is impossible to guarantee any specific results regarding you counseling goals. However, I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards.

The fee for each session will be due and must be paid at the beginning of each session. 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.

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

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.

Patient Signature _______________________________

Parent /Guardian Signature _________________________________
(If patient is fewer than 18)

Practitioner Signature_________________________________

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)