PATIENT REGISTRATION FORM

TODAY'S DATE _____ **PLEASE PRINT**

- **PATIENT'S** NAME _____
  Last First M.I.

HOME ADDRESS _____

CITY, STATE _____ ZIP CODE _____ GENDER: ☐ MALE ☐ FEMALE

BIRTH DATE _____ MARITAL STATUS _____

HOME PHONE # _____ SOCIAL SECURITY # _____

CELL PHONE # _____ STUDENT _____

- **EMPLOYER** _____ OCCUPATION _____

WORK ADDRESS _____

CITY, STATE _____ WORK PHONE # _____

REFERRAL NAME/SOURCE _____

PRIMARY CARE PHYSICIAN NAME & PHONE # _____

EMERGENCY CONTACT NAME & PHONE # _____

PREFERRED PHARMACY NAME & PHONE # _____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING INFORMATION:

The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service, regardless of insurance or divorce decree.

- **FATHER'S NAME** _____ BIRTH DATE _____

ADDRESS _____

CITY, ST, ZIP _____ HOME PHONE # _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____

CITY, ST, ZIP _____ WORK PHONE # _____

- **MOTHER'S NAME** _____ BIRTH DATE _____

ADDRESS _____

CITY, ST, ZIP _____ HOME PHONE # _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____

CITY, ST, ZIP _____ WORK PHONE # _____

INSURANCE INFORMATION

- **INSURED** NAME _____
  Last First M.I.

RELATIONSHIP TO PATIENT _____

NAME OF INSURED EMPLOYER _____

NAME OF INSURANCE CO. _____

INSURANCE COMPANY PHONE # _____

INSURED'S SOCIAL SEC. # _____ INSURED'S DOB _____

MEMBER/SUBSCRIBER ID _____ GROUP NUMBER _____

****

I UNDERSTAND AND AGREE THAT (<u>REGARDLESS OF MY INSURANCE STATUS</u>) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. I HAVE READ AND CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THE OFFICE STAFF OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

BY SIGNING BELOW, I HEREBY GIVE MY CONSENT TO THE PHYSICIANS AND OTHER CLINICAL PERSONNEL OF RICHARD B. PESIKOFF, M.D. AND ASSOCIATES FOR THE EVALUATION AND TREATMENT OF THE CONDITIONS WITH WHICH I PRESENT MYSELF TO THIS OFFICE.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS STATED IN THE OFFICE POLICIES INSERT. BY SIGNING BELOW, I HEREBY AGREE ON THE TERMS AND CONDITIONS AND ACKNOWLEDGE RECEIPT OF THE INFORMATION.

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

PERSONAL HISTORY FORM

A. Identification **PLEASE PRINT**

Name _____ Date _____

B. **Psychiatric Problems** *Reason for appointment and length of time problems have been present.*

_____

_____

C. **Symptoms** *Please check all that apply.*

☐ Anxiety	☐ Sleep Problems	☐ Panic Feelings	☐ Alcohol
☐ Depression	☐ Appetite Problems	☐ Voices	☐ Drugs
☐ Crying	☐ Hyperactivity	☐ Memory	☐ Legal
☐ Suicidal Thoughts	☐ Focusing	☐ Anger	☐ Tobacco
☐ Suicidal Acts	☐ Concentration	☐ Behavior	☐ Caffeine
☐ No Motivation	☐ Impulsivity		
☐ Other *(Describe)*			

D. Previous Psychiatric Problems

Names and dates of previous treating doctors or counselors and types of problems: _____

_____

Previous/Current Psychiatric Medications: _____

_____

Psychiatric Hospitalizations: _____

E. History of Family Psychiatric Problems and Family Health Problems

Please list any psychiatric problems within your family: _____

_____

a. Your Medical History *Please check if you have had any problems with:*

☐ Headaches	☐ Throat	☐ Urinary Tract	☐ Gastrointestinal
☐ Seizures	☐ Lungs	☐ Muscles	☐ Infectious Conditions
☐ Ears	☐ Heart	☐ Hormones	☐ Birth Issues
☐ Eyes	☐ Sexual (STD)	☐ Bones	☐ Other *please explain:* _____

For women, are you pregnant? ☐ Yes ☐ No Do you own a gun? ☐ Yes ☐ No

Any Drug Allergies: _____

F. Adult Issues

a. School history _____

b. Work history _____

c. Marriage (current/previous) _____

d. Social/friend relationships _____

e. Religious issues _____

f. Sexual issues _____

g. Number of children and ages _____

i. Military history _____

j. Drug Abuse (names, amounts, durations) _____

G. All current medications, doses and length of time taken _____

_____

H. Family History

Mother	Age _____	Occupation _____	Your relationship with her _____
Father	Age _____	Occupation _____	Your relationship with him _____
Sibling	Age _____	Occupation _____	Your relationship _____
Sibling	Age _____	Occupation _____	Your relationship _____
Sibling	Age _____	Occupation _____	Your relationship _____

NOTICE OF PRIVATE PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACT TO GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice and make the new Notice available upon request.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy policy and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our private practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our private practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use of disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $25 for the first 20 pages and $0.50 per sheet after that and staff time to locate and copy your health information, and postage if you want the copies mailed to. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary of an explanation of your information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 (six) years, but not before October 28, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Richard B. Pesikoff, M.D.

Telephone: (713)795-5454 Fax: (713)961-0008

Address: P.O. Box 540208 Houston, TX 77254

ACKNOWLEGEMENT OF RECEIPT OF THE NOTICE OF HIPAA PRIVACY AND SECURITY FOR PROTECTED HEALTH INFORMATION

Patient Name (Print or Type)

I hereby acknowledge that Dr. Richard Pesikoff's Office Staff has provided me with the information regarding the notice and how my health information will be disclosed for Treatment Payment Operation.

Patient Signature (required for all patients 16 years of age or older Date

Signature of Authorized Personal Representative Date

Patient Refused or Unable to Sign, but was given a Notice of Private Practices

Patient refused or was unable to sign for the following reason(s):

Witness Signature (Staff) Date

RICHARD B. PESIKOFF, M.D. & ASSOCIATES
Physical Address: 19 Briar Hollow Lane, Suite 102, Houston, TX 77027
Mailing Address: PO Box 540208, Houston, TX 77254
Office: (713)795-5424 Fax: (713)961-0008

OFFICE POLICIES

WELCOME!
We are committed to providing you with quality medical care and we are pleased to discuss our office policies at any time. Your clear understanding of our office policies is important to our professional relationship.

Please ask if you have any questions about our office policies, fees, financial policy, or your responsibility.

TO ASSIST US IN ESTABLISHING YOUR ACCOUNT, PLEASE PROVIDE THE FOLLOWING:

1. Current insurance information on your registrationform.
2. Please present your insurance card so that a copy may be made for yourchart.
3. A separately signed consent disclosure for authorization for the release of information necessary for filling your insurance claim(s), faxing orders, releasing medical information to other physicians and/or for insurance pre-certifications.
4. Please note that **all copays** designated by your insurance plan **will NOT be billed** and are **DUE AT THE TIME OF SERVICE**.

INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to your contract, though we may have a contractual fee schedule agreement with the insurance company. We will not become involved in disputes with your insurance regarding deductibles, non-covered/covered expenses, co-insurance or "reasonable and customary" charges other than to supply factual information as necessary. **You are responsible for timely payment of your account and for following up with your insurance company regarding claims**.
Our staff is very knowledgeable in referral authorization, pre-certifications and pre-authorization procedures for all insurance plans. Please note that at times, you may be required to contact your insurance company regarding specific mental health benefits and/or prior authorizations.
Being knowledgeable about your insurance policy and referrals is to your benefit and proper claim(s) payment.

It is your responsibility to provide the office with any changes or updates to your insurance plan.

Medicaid: We are no longer participating providers with Medicaid. You may establish or continue treatment at our office on a **self-pay** basis only.

Medicare: We are no longer participating providers with Medicare. If Medicare is primary, we do not file with your secondary or supplementary policy. You may establish or continue treatment at our office on a **self-pay** basis only.

Our office does NOT file third insurance policies.

Indemnity/Fee for Service: As a courtesy to our patients, we file with your insurance provided you have met your annual deductible and pay your co-insurance as the time of service. *If you have not met your deductible you must pay at the time of service and a claim will be filled with your insurance, upon request.*

Contracted Managed Health Care: (HMOs, PPOs, EPOs) **It is your responsibility to make sure that our physician is currently enrolled with your plan. All necessary referrals must have been obtained prior to each visit**. If your referral has not been completed prior to your arrival in the office, it may mean a delay in being seen by the physician and the possible rescheduling of your appointment. You are obligated by your insurance company to pay the co-pay at the time of your visit.

Worker's Compensation: We **DO NOT ACCEPT** Worker's Compensation patients.

APPOINTMENTS

Please make note that reminder calls are a courtesy. You are ultimately responsible for your appointment whether

your reminder was received or not.

Due to frequent rescheduling and/or cancellations of appointments by our patients in the past, it has become necessary to apply an administrative charge for missed appointments and/or same day (non-emergency) cancellations.
A PATIENT WHO RESCHEDULES OR CANCELS WITHIN 24 HOURS OF THE SCHEDULED APPOINTMENT FOR ANY REASON OTHER THAN A MEDICAL CONDITION OR OTHER EMERGENCY ISSUES (DETERMINED AT THE DISCRETION OF THE OFFICE) WILL BE CHARGED A $60 FEE.

Please make note that if you miss an appointment, the $60 fee must be paid BEFORE rescheduling the appointment.

If you are running late, we ask that you contact our office to let us know. If you fail to contact the office and show up more than 10 minutes late to your appointment, you may need to be rescheduled for a different day and will be charged for a missed appointment.

If you miss two appointments, at the discretion of the office, you will be sent a termination letter and will not be permitted to schedule another appointment.

Although the clinicians try their best to stay on schedule, we ask that you make time in your schedule in case you encounter a longer than normal wait time. This is not a common occurrence, but we ask for your patience and courtesy, should this occur.

ON-CALL CLINICIAN SERVICES
In the event of an urgent psychiatric matter outside of regular business hours, you may contact the on-call clinician by calling the office and following the appropriate prompts on our telephone greeting. You will be connected to the voicemail box of the on-call clinician. Leave a brief message with your name, return phone number and the nature of your emergency. You will receive a return telephone call promptly. Please note that this service should be utilized for urgent matters that cannot wait until the next business day (i.e. suicidal thoughts or thoughts of harming self and/or others, serious medication reactions, or unusual behavior that may lead to physical harm). Non-urgent issues (i.e. medication refills, scheduling or billing questions) may be addressed via telephone during our regular business hours.

Calls placed for non-emergent issues will result in being charged a $25 fee for after-hours care. Additionally, if the matter is not urgent or emergent, you may not receive a return a call from the on-call provider.

EMERGENCY CARE
In the event of a life-threatening emergency, please call 911 or go to the nearest Emergency Room. Do not delay care by waiting for a response from our on-call provider.

MINORS/UNACCOMPANIED MINORS (less than 18 years of age)
1. ONLY the patient shall be accompanied by his/her parent(s) and/or legal guardian(s). We ask that you DO NOT bring any baby carriages or other children to our office. This creates a distraction and a higher noise level than our building would like. Please make arrangements prior to the appointment so this does not occur.
2. The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decreestatus.
3. The parent(s) or legal guardian(s) for an unaccompanied minor must provide authorization for medical treatment and is responsible for providing current insurance information and any necessary payment at the time ofservice.

ADDITIONAL FEES
1. There is a charge for all letters and forms (including but not limited to FMLA forms, Short and Long Term Disability, Social Security Disability, etc.). This fee ranges from $35 - $50, depending on the length and nature of the paperwork. The exact charge will be determined by the office staff.
2. There is a fee for all medical records request. $25 for the first 20 pages and $0.50 per sheet thereafter.
3. There is a $25 fee on all returned checks.
4. There is a $10 processing fee for C-II prescriptions that have to be mailed out.
5. There is a $25 fee to replace expired, lost or stolen C-II paperprescriptions.

MEMBER RIGHTS AND RESPOSIBILITY STATEMENT
for
Condition Care Management

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be release without the members' permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Given input on the Members' Right and Responsibilities.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of their treatment needs.
- Decline participation or withdraw from programs and services.
- Know which staff members are responsible for managing their services and from whom to request a change in services.

Statement of Members' Responsibility

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information that they need. This is so providers can deliver quality and appropriate care.
- Ask questions about their care. This is to help them understand their care.
- Follow treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell the provider and primary care physician about medication changes, including medications given to them by other providers.
- Keep their appointments. Members should call as soon as they know they need to cancel or reschedule appointments.
- Let the provider know about problem with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let their insurance and provider(s) know if they decide to withdraw from the program.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

Provider Signature Date