Patient Information and Consent

Please Print

Patient Name

Legal First Name | Legal Last Name | Suffix | Preferred First Name

Today's Visit

What is the reason for your visit today? _____

Have you been treated by a mental health provider before? ☐ Yes ☐ No

Have there been any changes to *your information* in the past 6 months? ☐ Yes ☐ No (if no, please skip to the back page)

Patient Demographics

Permanent Address | Apt. # | City | State | Zip

Phone # | Social Security # | Gender | Birth Date

Language | Marital Status | Email Address (We will never rent or sell your email address – we value your privacy.)

Local or Alternate Address | Alternate Phone # | Today's Date

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Mixed Race ☐ White ☐ Other ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refuse to Report

Emergency Contact Information

Contact Name | Phone # | Relationship to Patient

Name of a Relative not Residing With You | Phone #

Patient Employment Information

Employer Name | Employer Phone #

Responsible Party's Information (if someone other than patient)

Legal Name of Responsible Party | Social Security # | Address | City | State | Zip

Medical Insurance Information (if applicable)

Insurance Company | Policy Holder's Name | Policy Holder's Relationship to Patient

Policy Holder's Address | City | State | Zip

Policy Holder's Birth Date | Policy Holder's Social Security # | Policy Holder's Employer

PLEASE TURN THIS FORM OVER AND COMPLETE THE BACK

Patient Consent for Treatment

1. I voluntarily consent to any and all health care treatment and diagnostic procedures provided by CCOSA and its associated clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at CCOSA.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the CCOSA Notice of Privacy Practices.
3. I authorize payment of medical benefits to CCOSA clinicians or their designee for services rendered.

I have received a copy of the Notice of Privacy Practice, Financial Policy Notice and the Release of Information. ☐ Yes ☐ No Initial_____

_____ _____

Patient or Authorized Person's Signature Date

FOR INTERNAL USE ONLY

EHR Account Number: _____ Payment Collected: $ _____

EHR DOCUMENT TYPE: Client Information

Patient History

G A D – 7

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every Day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 NOT being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

A12 – GAD7 total score ☐

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every Day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

A11 – PHQ9 total score ☐

CAGE Scale

Please check the one response to each item that best describes how you have felt and behaved over your whole life.

Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? ☐ Yes ☐ No

Notice of Privacy Practices: CCOSA, LLC

Please Read and Sign

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

Patient Health Information (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI)

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights

You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area and on our website at www.DoctorsCare.com. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

CCOSA
Attn: Privacy Officer
PO Box 460429
San Antonio, TX 78246

Complaints Management and
Investigative Section
P.O. Box 141369
Austin, Texas 78714

Email: counselingconnections.sa@gmail.com

Patient Acknowledgement

My signature verifies that I have been provided a copy of CCOSA "Notice of Privacy Practices" to review. I understand that if I would like a copy of this Notice, CCOSA will provide me with a copy of this documentation.

Patient's Name (please print)	Date of Birth	Signature	Today's Date

EFFECTIVE January 2018

EHR DOCUMENT TYPE: Client Information

Authorization for Release of Information

Patient Name: _____ DOB: _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results tests/screenings ☐ Other: _____
☐ Spouse (provide name & phone number) _____	☐ Financial ☐ Medical
☐ OTHER (provide name & phone number) _____	☐ Financial ☐ Medical
☐ Email communication (provide email address)* _____	☐ Financial ☐ Medical ☐ Breach Notification

*In order for email communication to occur, please accept the disclosure below:

_____ I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed
Initial inappropriately. I still elect to receive email communication.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

Financial Policy and Disclosure

Please Sign and Date

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by CCOSA and Clinical Affiliates.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at discharge.
- Any self-pay (non-insurance client) is required to place a credit card on file and/or pre-pay for services in advance.

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that *is not covered* by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Overdue and Credit Balances

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.
- Credit balances under $15 aged over 60 days may be written off.

No-Show or Late Cancellations

- If you do not show or are more than 15 minutes late to your scheduled appointment, you accept a charge of $50.00 per hour scheduled (prorated if more than one hour is reserved).
- You accept that the fee must be paid prior to rescheduling for services.
- In special cases, this fee may be waived due to emergency services (i.e. ER or Urgent Care visit).

Divorce or Custody Case Policy

- The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

Please discuss any account information with front desk associate or ask for our billing representatives' contact information.

Responsible Party's Signature _____ Date _____

Your cooperation is greatly appreciated.