Gulf Coast Behavioral Clinic Welcomes You!

3126 Rodd Field Road * Corpus Christi, TX 78414
Tel: 361-452-6898 Fax: 361-452-6870
www.gcbclinic.com

PATIENT INFORMATION

How did you hear about us?/Referred by: ______________________________

First Name	Last Name	Middle Name
Mailing Address	City/State	Zip
Home Phone	Mobile Phone	email
Date of Birth	Gender	Marital Status

RESPONSIBLE PARTY INFORMATION (if different from above)

Relationship to patient: Parent/Guardian ________ Spouse ________ Other (please indicate): ________

First Name	Last Name	Middle Name
Mailing Address	City/State	Zip
Home Phone	Mobile Phone	email

PAYMENT AND INSURANCE INFORMATION

Insurance Carrier	Policy Number	Group Number
Name of Policy Holder	Policy Holder's Date of Birth	Policy Holder's SSN

1. I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department. If using insurance, I hereby authorize the release of any information regarding my/my child's condition or treatment to my insurance company. I also authorize the payment of insurance benefits from my insurance company to my provider.

SIGNED: ______________________________ Client or Guardian (if client is a minor)

Printed Name ______________________________ DATE: ____________________

GULF COAST BEHAVIORAL CLINIC GENERAL POLICIES AND PROCEDURES

Length of Session: Initial Evaluation may last from 30 to 45 min. Follow- up treatment and medication management sessions last about 10- 15 min.

Fee Structure: The client is financially responsible for payment of fees, which will be collected at the time of service. The client will also be responsible for any portion of fees not reimbursed or covered by health insurance. Co-pays are non-refundable. Additional cost may be incurred for use of assessment instruments.

Cancellations: Your appointment time is reserved for you and is taken seriously. Except for emergencies, cancellations must be made 24 hours in advance to avoid being charged a $25 rescheduling fee.

Confidentiality: Information shared is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony requires by a judge, personal danger to self or an identifiable victim); information provided to parents if the client is a minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent.

Client Privacy: Your privacy is important to us. Please be advised that non-encrypted email and cellular phone communication is not secure and can potentially be intercepted by a third-party. By signing this document, you agree that you understand and accept the risk involved in choosing to communicate with us through these means.

Treatment Participation: The psychiatrist and/or nurse practitioner's ability to help you is dependent on your level of participation in the treatment process. Follow up appointments are scheduled at the discretion of your provider. Please be advised that your provider may order additional testing (such as blood and/or urine analysis) or recommend including certain family members in your treatment. Declining to participate or repeated appointment cancellations may result in a referral to another provider.

Prescriptions and Refills: Prescription will be given to you at the time of visit. All medications prescribed should be taken as directed. Additional refills will be given at the discretion of the doctor and may require additional follow-up visits.

I, the undersigned, confirm that I have read, understood and agree to comply with the general policies of Gulf Coast Behavioral Clinic and give my informed consent to enter into the psychological treatment process.

SIGNED: ______________________________ Client or Guardian (if client is a minor)

Printed Name ______________________________ DATE: ____________________

NOTICE OF PRIVACY PRACTICES

Effective April 29, 2015

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how your provider may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

HOW YOUR PROVIDER MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

For Payment: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI in order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, your provider must make disclosures of your PHI to you upon your request. In addition, disclosures must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.
- Required by Court Order

- Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider:

Right of Access to Inspect and Copy. In most cases, you have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that your provider makes of your PHI. Your provider may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. Your provider is not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of This Notice. You may ask your provider for a paper copy of this notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the Federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Government, contact:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service.

Client Name: ______________________ Client Signature: ______________________

Date: ______________________

If signed by other than client, indicate relationship:

____

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name:_______________________________ Date of Birth: ______________________

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your provider any questions or concerns you may have.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: _______________________________ Date: ________________

Parent/Guardian Signature: _______________________ Date: ________________
(for minor)

Gulf Coast Behavioral Clinic

3126 Rodd Field Rd
Corpus Christi, TX 78414

Medical Information Authorization

Patient Name: ____________________________ Date of Birth ____/____/____

I authorize the personnel of Gulf Coast Behavioral Clinic to release all medical information to my family members, friends, school officials and/or medical professionals listed below.

I may revoke this authorization in writing at any time.

Name	Relationship to Patient	Phone Number(s)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Permission to leave a message on an answering machine or voice-mail ____ Yes ____ No

______________________________ Patient/Guardian Signature

_____/_____/_____ Today's Date