GREATER HEIGHTS HOLISTIC PSYCHIATRY

1919 N. Loop W., Suite #280 | Houston, TX 77008
Phone: 832-930-1202 | Fax: 832-304-6385

NEW PATIENT DEMOGRAPHIC INFORMATION

Please complete all information on this form and bring it to the first visit

General Information:

Last Name:		First Name:		
DOB:	Age:	Legal Sex:	Weight:	Height:
Street Address		Apt No	City	State Zip code
Cell phone number:			Home number:	
Agree to receive a voice/text message? Y/N				
Email:				

Insurance Information:

Active Primary insurance: Insurance company_____

Policy ID_____Group ID_____

Policy Holder's name_____

Relationship to patient_____

Active Secondary insurance: Insurance company_____

Policy ID_____Group ID_____

Policy Holder's name_____

Relationship to patient_____

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Primary Guarantor Information:

Last name_____First name_____

Contact Phone#_____Relationship to patient_____

Address_____

_____

Emergency Contact:

Last Name:	First Name:
Relationship:	Phone:

Preferred Pharmacy:

Address:	
Phone:	Fax:

Current Psychiatric Medications with dosage:

Past Psychiatric Medications with dosage:

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CLINIC POLICIES AND PROCEDURES

Thank you for choosing Greater Heights Holistic Psychiatry (GHHP) for your psychiatric care. In order to prevent any misunderstandings and to facilitate the treatment of all patients, the following clinical policies are provided to serve you better. For purposes of this notice, the use of the word "office" should be taken to mean Greater Heights Holistic Psychiatry. In all cases where the words "you" or "patient" are used, it should be taken to mean "the patient or their parent/legal guardian/guarantor". **Please read the entire document before signing that you acknowledge and understand our policies.**

OFFICE HOURS

- Monday – Friday 8:00 am – 5:00 pm
- Patients are seen by appointment only. Walk-in appointments cannot be accommodated, but every effort will be made to schedule an earlier appointment.

APPOINTMENT SCHEDULING & CANCELLATIONS

- The office provides appointment reminders as a courtesy service, but the reminder cannot be relied upon. It is the patient's responsibility to provide up to date contact information and remember the time and date of the appointment.
- Please arrive/login on time for appointments. Patients expecting to be late for their appointments should notify the office. Patients who arrive more than 10 minutes after their scheduled arrival time, will not be seen, will be rescheduled, and automatically charged the following NLCR fee for the time lost:
  - $200- For new patient
  - $100-For follow up patient
- Patients are expected to notify the office of cancellation 48 business hours prior to their appointment. In case of no show, late cancellation, or late rescheduling, above fee will be automatically charged to the credit card on file. This fee is not reimbursable by your insurance company. For any cancellation it is mandatory to send an email to cancellations@psychiatryhoustontx.com.
- Confirming your appointment is mandatory, as not doing so may result in NLCR fee or cancellation of the appointment or both.
- Patients cancelling or no-showing for 3 appointments in a year may be terminated from our clinic.

EMERGENCIES AND URGENCIES

- In the event of a life-threatening psychiatric emergency/urgency (suicidal urges, threats, or behavior; physically or verbally threatening behavior; or abrupt and severe medical changes) **CALL 911 IMMEDIATELY** or go to your nearest ER room.
- For non-urgent issues please call our clinic number or send a message via patient portal and every effort will be made to respond to your call within 72 business hours.
- **All non-urgent after-hour phone calls, including prescription refill requests will include a $100 fee per 15 minutes. This fee is not reimbursable by your insurance company.**

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DIAGNOSING ADHD & TREATMENT INVOLVING STIMULANT MEDICATIONS

- An accurate diagnosis of ADHD is overly complex, especially in adult cases. We use a combination of clinical interviewing, collateral information from family, workplace and TOVA test, which is FDA approved to measure inattention. In the case of children and adults with a previous diagnosis – patients are required to bring any medical records at the time of or before your initial appointment.
- Without any previous psychological testing/medical records, a TOVA testing could be recommended which can be done in the office. **The cost for the TOVA test is $150 and this is not reimbursable by your insurance company.** Detailed psychological testing might be required in some cases despite the TOVA testing.
- A urine drug screen (UDS) might be done or ordered during the initial visit or before starting the controlled substance. Random UDS might be done or ordered during your follow up visits. When you are initially prescribed a stimulant, you may need to be monitored frequently. Once the dose has been stabilized, your appointments need to be scheduled 28-30 days from your last appointment.
- Controlled substances will be prescribed only during a visit. Paper prescriptions will not be provided and in case one is given due to system failure, it is the patient's responsibility to keep it safe. No refill will be provided in case you lose paper prescription, unless you provide a police report for the loss of paper prescription.

MEDICATIONS REFILL REQUESTS / PRIOR AUTHORIZATION

- It is not advised that a patient abruptly discontinue any medications. Interruption of regularly scheduled medications can potentially cause unpleasant, sometimes dangerous withdrawal symptoms or a relapse of the condition being treated.
- Controlled substances will **NOT** be refilled without an office visit or telemedicine visit.
- Follow-up appointments must be scheduled and kept in order for a refill request to be approved.
- GHHP does not send med refills out of state
- The office staff will make every attempt to schedule the patient's follow up appointments, but it is the patient's responsibility to schedule the appointment in advance to avoid any refill fee. Any refills will be provided only during the appointment.
- **Refills arising out of a missed patient appointment will incur a $30 refill fee. (Payment is due prior to refill being approved).**
- All refill requests must be submitted via fax, call, or electronic request from your pharmacy.
- Please allow **72 business hours** for the refill request to be completed. Refill requests will NOT be processed on a weekend or holiday.
- Certain medications may require prior authorization from your insurance company. This may take several weeks, depending on your insurance plans. Please note that filing of an authorization does not guarantee your insurance will approve the request.
- There is a **$30 fee** for each authorization that our office has to obtain. This fee must be paid before the prior authorization is processed. Prior Authorizations are typically done on Fridays or over the weekend.
- We advise each patient to obtain a copy of your formulary list prior to your visit to ensure that the medications are covered by your insurance company and to give you the opportunity to discuss alternatives if possible.
- New symptoms will require an appointment; the physician will not diagnose or change any medication via telephone or email.

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- If you develop any adverse drug reaction, please inform GHHP immediately. Please go to the nearest Emergency Room if symptoms are severe or life threatening. For any urgent concerns which can wait for 48 hours, all attempts will be made to address the issue as soon as possible by giving the earliest possible appointments.

INSURANCE AND PHARMACY BENEFITS

- A valid state issued photo ID and a copy of the insurance card(s) must be supplied by the patient or guarantor. It is your responsibility to contact your medical insurance plan to determine what benefits and services provided are covered or if the GHHP provider is in their network.
- GHHP is only able to accurately bill an insurance carrier when provided with correct information. It is the patient's responsibility to submit any change of insurance to the receptionist at the time of his or her visit along with the appropriate referral, if needed. This includes providing the office with a copy of the actual insurance card and your photo identification.
- GHHP must be notified at least 48 hours prior to appointment of any changes in the insurance. New insurance without verification will result in a co-pay of the allowable amount designated by your insurance company.
- If billing errors occur due to the patient's failure to submit correct information, the office will not be held liable and it is the patient's responsibility to pay the full fee for the services rendered.
- Pharmacy benefits vary greatly from one plan to the other. GHHP understands insurance restrictions and attempts to prescribe in a manner which is mutually agreeable to both patients and their insurance carriers. However, GHHP cannot predict how any specific medication will b e c overed b y a patient's plan. It is your responsibility to know about your pharmacy benefits, at the time of appointment.

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 copay at the time of your visit.

FINANCIAL POLICY

- In consideration for the services to be rendered to the patient; the patient assumes full financial responsibility for the payment of the patient's account. GHHP will collect your co-pay/co-insurance responsibility the morning of appointment, irrespective of the timing of the appointment during the day. GHHP accepts all methods of payments except checks. If you are unable to pay during the morning of the appointment it will be rescheduled.
- You understand that you are financially responsible for all services whether or not covered by your insurance.
- You are responsible for all balances on the account, which your insurance has determined as the patient's responsibility based upon the benefits. Insurance companies do not guarantee benefits quoted, nor do they guarantee payment. You will be responsible for services not paid by your insurance. Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 60 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues.

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If your insurance company denies payment for services rendered by GHHP on grounds that the services are not medically necessary, this consent allows GHHP to collect payment from you for the services rendered. Your credit card will be automatically charged for the balance unpaid by your insurance company.

- If you choose to be a self-pay patient the full amount will be collected at the time of scheduling the appointment. If you do not show up for your appointment, then the NLCR fee will be charged as per our NLCR policy.
- Adult Patient Self-Pay rate:
  - Initial Psychiatric Evaluation: $300
  - Follow up Appointments: $150
- Child and Adolescent Patient Self-Pay rate:
  - Initial Psychiatric Evaluation: $400
  - Follow up appointment: $200 (An adult has to be present during the appointment).

FORMS & MEDICAL RECORDS POLICIES

Filling out any paperwork is at the sole discretion of the clinic. Clinic will need up to 2 weeks to fill out any type of paperwork.

The cost to fill out forms is based on time spent by the provider/office staff to complete the request.

Under 15 mins.	**$100**
16-30 mins.	**$200**
31-45 mins.	**$300**
46-60 mins.	**$400**

- GHHP does NOT fill out long-term, short-term disability paperwork.
- Emotional Support Animal letters - **$200**
- Medical Records Fee:
  - $25 for retrieval of records and processing the request; pages 1-20
  - $0.50 per page thereafter.
  - This does not include mail charges

LITIGATION POLICY AND FEES FOR COURT RELATED SERVICES

It is important to our practice that we accessible to as many patients as possible throughout the day. For this reason, we want to avoid at all costs being involved in any legal commitments such as ligations, Subpoenas, deposition, etc. On behalf of an individual patients' legal disputes. Legal commitments such as these takes our providers away from the practice, and in essence away from patient care. If any case you are to become involved in any legal proceeding during your care with our providers including but not limited to divorce and custody disputes, or personal injury lawsuit, you agree that neither you, nor your attorney, nor anyone acting on your behalf will subpoena records from our practice, or subpoena our clinic to testify in court, in a deposition or in any legal proceeding. If we are involved in your litigations or if your attorneys subpoena our providers or staff to provide medical records, testify in court or give deposition in violation of this agreement, we will have no choice but to comply. For this our providers will require compensation.

The Hourly charge for all time related court cases or litigation is $1000 per hour. You will be asked to sign a credit card Authorization and provide a valid credit card to ensure payment for the time we must spend

dealing with litigation, and by your signature below, you agree not to contest any fees that you are charged to your credit card as a result of this agreement, and specifically, this section of this agreement. If we are subpoenaed to provide records or testimony in violation of this agreement you acknowledge and agree that you will be billed for the provider's professional time including but not limited to preparation, record review, transportation charges (door to door), Waiting time, and spent time testifying in court or deposition regardless of which party issues the subpoena or requires us to testify. If we are required to testify in court or give a deposition in Harris County, we will charge a retainer in the amount of $4000 (a minimum of 4 hours at $1000 per hour). If the testimony or deposition requires testimony or deposition outside of Harris County, the retainer will be $6000 (a minimum of 6 hours at $1000 Per hour), Which includes preparation time, travel time (door to door), and attendance at any legal proceeding. If the testimony or deposition exceeds the retainer of 4 hours (in Harris County) or the retainer for 6hours outside (Harris County), We will bill each additional hour spent attending a court hearing or deposition and we will charge your credit card for the balance.

In order to go to court or give deposition, Providers needs to reschedule their appointments to clear their day, therefore there is a 48-hour cancelation policy for court depositions. For example, if the court appearance or deposition is scheduled for a Monday, this office must be notified of any cancellation no later than noon on the Thursday before. Any cancelation that occurs within the 48-hour time frame of court appearance or deposition are NONREFUNDABLE. We will accept cash, money order, Cashier's check, or credit card for payment of time related to court appearances or deposition. No PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES. All payments are due 48 hours prior to the scheduled court appearance or deposition, and no later than 12:00noon on us to return these charges to the credit card on file in our office unless you notify our office that you intend to make payment by cash, money order or cashier's check.

We will not perform forensic psychiatry or custody evaluations. We will not conduct assessments for FMLA, short-term or long-term disability applications. We will not provide recommendations regarding possession, custody, access to or visitation with minor children

PATIENT AND STAFF SAFETY COMPLAINTS

- At GHHP we strive to provide excellent care to all patients and staff members. Health care relationship is mutual between a patient and staff members of our clinic. We do not tolerate any disrespectful behavior including not being limited to verbal disrespect and profane language, from our staff towards the patients and vice versa.
- If we fail to meet your expectations, please contact our clinic (832-930-1202) and ask for our Office Manager. If the manager is unavailable, please leave a message and someone or a provider will contact you within 7 business days.
- If you, as the patient fail to meet the expectations, and a staff member is disrespected the same rights are given to all our staff members to report to GHHP management in writing regarding the patient's behavior. After that, the decision to terminate patient's services from GHHP will be made by GHHP management.

TREATMENT CONSENT POLICY

- I hereby consent to receive treatment from Staff of GHHP for my mental illness which includes but is not limited to history and examination, diagnostic & prognostic testing, therapy, and any other recommended treatment regimen.

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- I understand that my treatment plan will be explained to me during my office visit and that I have the right to refuse and/or discontinue the treatment at any time. I understand that I may be prescribed medications to help my mental or emotional condition. Any side effects of these medications will be explained to me during the appointment, and I can request for a printed copy of common side effects.
- In order to receive proper care, I must accept certain responsibilities. I am responsible for providing accurate and complete information about matters relating to the patient's health and for reporting changes in the patient's condition. I am responsible for following the treatment plan recommended by the provider and reporting any side effects to the provider. If treatment is refused or directions given by the providers are not followed, I am responsible for the actions and the consequences of those actions.
- I have requested services from the GHHP on behalf of myself and/or my dependents. I hereby authorize GHHP to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

HIPAA NOTICE OF PRIVACY PRACTICES

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

Greater Heights Holistic Psychiatry has a legal duty to safeguard your protected health information ("PHI") and keep it private. PHI constitutes information created or noted by this office that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or payment for such health care. This notice is required to explain when, why, and how your PHI would be used and/or disclosed by this office. Use of PHI is when information is shared, applied, utilized, examined, or analyzed within the office; disclosure of PHI is when information is released, transferred, given, or otherwise revealed to a third party outside of this office. With some exceptions, your PHI will not be used or disclosed more than is necessary to accomplish the purpose for which the use or disclosure is made. Following the privacy practices described in this notice is legally required. Any changes to these practices will apply to PHI already on file. Before any changes to policies are made, this notice may be modified and a new copy of it will be posted in the office and on the website. You may also request a copy of this notice from our office.

Your PHI may be used and disclosed for many different reasons. Some of the uses or disclosures will require your prior written authorization; however, others will not.

Uses and disclosures related to treatment, payment, or office health care operations do not require your prior written consent:

- **For treatment**. Your health information may be used to give you medical treatment or services. Your PHI may be disclosed to pharmacists and their assistants, and other professionals involved in your care to put in place a treatment plan and to carry out that plan. For example, your PHI may be provided to clarify medication instructions with a pharmacy, obtain prior authorization for certain medications from insurance entities, or disclose health information to physicians who provide follow-up care to you.
- **For health care operations**. Your PHI may be disclosed to facilitate the efficient and correct operation of this medical practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, conducting business or arranging for other related activities.

- **To obtain payment for treatment**. Your PHI may be used and disclosed to bill and/or collect payment for the treatment and services provided to you.
- **Minors**. If you are an unemancipated minor (i.e., not legally authorized to act as adult) under Texas law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis, in accordance with our legal and ethical responsibilities.
- **Parents**. If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you in certain circumstances. If we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you. In some circumstances, we may not disclose health information about an unemancipated minor to you. If your child is legally authorized to consent for treatment, we may not disclose health information about your child to you without your child's written permission.
- **Other disclosures**. Your consent is not required if you need emergency treatment. In the event that this office tries to get your consent, but you are unable to communicate (e.g., unconscious), but it is reasonable to assume that you would consent to such treatment if you could, your PHI may be disclosed.
- **Required by law**. This office may make a disclosure to the appropriate officials when a law requires reporting information to government agencies, law enforcement personnel, and/or administrative proceedings.
- **Disclosure** may be compelled by a party to a proceeding before a court or an administrative agency pursuant to its lawful authority, or if a search warrant is lawfully issued to a law enforcement agency.
- **Health and safety codes and federal regulations**. Disclosure may be compelled by the patient or the patient's representative pursuant to Texas Health and Safety Codes or to corresponding federal statutes or regulations, such as the privacy rule that requires this notice.
- **To avoid harm**. PHI may be provided to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person including yourself or the public. This includes when disclosure is necessary to prevent the threat of danger from occurring.
- **Child/elder abuse and neglect**. Disclosure may be mandated by the Texas child abuse and neglect reporting law or the Texas elder/dependent adult abuse reporting laws.
- **Threat of violence**. Disclosure may be compelled or permitted by the fact that you tell this office of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
- **Public health**. Disclosure may be permitted to public health officials, if required.

- **Health oversight activities**. This office may be required to provide information to assist the government in the course of an investigation or inspection of a health care Organization.
- **Specific government functions**. PHI may be disclosed as a matter of national security.
- **Worker's compensation purposes**. In certain circumstances, PHI may be provided in order to comply with workers' compensation laws.
- **Appointment reminders and health related benefits/services**. PHI may be used to provide appointment reminders.
- If disclosure is otherwise specifically required by law.

RIGHTS REGARDING YOUR PHI

You have the right to inspect and copy your PHI that is in our possession; however, you must request it in writing. You will receive a response within 15 days of our receipt of your written request. Under certain

circumstances, your request may be denied. If so, you will receive the reason for denial in writing. You also have the right to have the denial reviewed. The charge for copying PHI is allowed by state law. You have the right to ask that use and disclosure of your PHI be limited, but this office is not legally bound to agree. If your request is agreed to, those limits will be put in writing and abided by except in emergency situations. You do not have the right to limit the uses and disclosures that this office is legally required or permitted to make.

You have the right to choose how your PHI is sent to you. It is your right to ask that your PHI be sent to you at an alternate address. This office may agree to your request providing that the PHI can be rendered in the format you requested without undue inconvenience.

You have the right to amend your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request correction of the existing information or addition of the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of receipt of your request. Your request may be denied if the PHI is correct, complete, forbidden to be disclosed, not part of the records, or written by someone other than this office. Denials will be provided in writing. If approved, the change(s) will be made to your PHI.

I further understand that any person who receives the medical records, will not release any of the medical information disclosed by this authorization to any other person or organization without authorization signed by me for release of the information. In other situations, not described above, written authorization from the patient will be requested before using or disclosing any of your PHI. If you have signed an authorization to disclose your PHI, you may later revoke that authorization in writing to stop further disclosures.

If, in your opinion, your privacy rights have been violated, or if you object to a decision made about access to your PHI, you are entitled to file a complaint with Greater Heights Holistic Psychiatry by calling 832-930-1202, or by sending a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

I authorize GHHP and or any third-party organization assigned to the account to contact me at the telephone number, cellular number or email provided. Contact regarding my health condition may be performed with the use of pre-recorded messages, automatic dialing service, electronic email, text messaging, artificial voice messaging or personal calls regarding health care related notices or my obligation of payment for services.

I allow Greater Heights Holistic Psychiatry to leave a voicemail/text about PHI at the following numbers. If you chose to disagree with voicemail/text regarding PHI, exception to this rule will still apply to automated appointment reminders sent to the patient's phone/email. If you do not wish to receive automated reminders or messages, it is your responsibility to block those in your phone/email (check all that apply):

Home Telephone: _____ Cell Phone: _____

INFORMED CONSENT FOR TELEPSYCHIATRY

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include appointment scheduling, communication via email or electronic chat, electronic scheduling, electronic

prescribing, and the distribution of patient education materials and forms. In order to receive telepsychiatry services from GHHP you must be a resident of the State of Texas. It is your responsibility to ensure that you are located in Texas at the time of your appointment, GHHP will not be liable for any issues arising from your location at the time of appointment. Your medications will only be sent within the state of Texas.

The potential benefits of telepsychiatry are:

- Reduced wait time to receive psychiatric care.
- Avoiding the need to travel to a psychiatrist.

The potential risks of telepsychiatry include, but are not limited to:

- A telepsychiatry session will not be exactly the same and may not be as complete as face-to-face service.
- There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session and affect the decision-making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care if needed.
- The provider may not be able to perform certain physical exam parameters, or check vital signs (weight, blood pressure) as in a face-to-face session.
- A lack of access to all the information that might be available in a face-to-face session, but not in a telepsychiatry session, may result in errors in judgment.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- GHHP utilizes software that meets the recommended standards to protect the privacy and security of the telepsychiatry sessions. However, the service cannot guarantee total protection against hacking or tapping into the telepsychiatry session by outsiders.

Alternatives to the use of telepsychiatry: Traditional face-to-face sessions will be provided only when COVID-19 situation, or the presence of any Public Health Crisis, is better.

PATIENT'S RESPONSIBILITIES

- I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. Any cancellation resulting due to issues arising from technology failure on part patient, will result in late cancellation for the patient. This fee is not covered by the insurance.
- I understand that my psychiatrist determines whether or not the condition being diagnosed and/treated is appropriate for a telepsychiatry encounter.
- I understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment but if this is done while the session is going on, full clinic fee will be charged to the patient's credit card on file. This fee will not be reimbursed by the insurance due to patient withdrawing consent in the middle of the session.

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- I understand that GHHP has the right to withhold or withdraw from providing telepsychiatry care at any time.

I hereby consent to engage in telepsychiatry services with GHHP as part of my psychiatric evaluation and treatment. I have read and understand the information provided regarding telepsychiatry and all my questions have been answered by the GHHP staff member.

DECLARATION & ACKNOWLEDGEMENT OF ALL OFFICE POLICIES

I hereby acknowledge that I have reviewed and agree with all the above policies and consent to all terms and consequences. I understand that I am entitled to receive a copy of this document.

By signing the clinic policies, I agree with all policies and procedures as defined by GHHP, PLLC. Failure to abide by these clinic policies will result in termination of treatment for noncompliance of policies. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement. All of my questions have been fully answered by the GHHP staff.

I hereby acknowledge that the Clinic Policies have been made available to me for review. I am aware that the policies for this practice may change from time to time and that the current copy of the policy is always available upon request from the GHHP staff. I understand that the clinic is not responsible for providing me the updated policy and it is my responsibility to request GHHP staff in writing.

If you are filling this form electronically, then typing your name in this field will be equivalent to signing your name on a paper document.

Patient's/Guardian's Signature: _____ Date: _____

Patient's/Guardian's Name: _____

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MEDICAL RECORDS RELEASE FORM

Patient's Name:_____

Patient's Date of Birth:_____

Parent's/Legal Guardian's Name:_____

I authorize to release all my medical records, from date_____to_____, including but not limited to, initial psychiatric evaluation, history and physical, progress notes,procedure notes, medication history and lab reports (check either 1 or 2):

1. to Greater Heights Holistic Psychiatry from the following provider(s):

2. from Greater Heights Holistic Psychiatry to the following provider(s):

Provider's Name:_____

Address:_____

City, State, Zip:_____

Phone Number:_____

Fax Number:_____

I understand that this form will be in effect for 1 year after termination of care from Greater Heights Holistic Psychiatry clinic. I understand that I can revoke this consent in writing at anytime.

_____

Patient's/Guardian's Signature

_____

Date

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CREDIT CARD AGREEMENT FORM

I agree to allow Greater Heights Holistic Psychiatry PLLC to run my debit/credit card forany unpaid balances each month. I further agree to allow Greater Heights Holistic Psychiatry, PLLC to run my debit/credit card for any no-show fees and/or NSF(non-sufficient funds) bank charges at the time they are accrued.

Debit/Credit Card Information:

☐Visa, ☐Mastercard, ☐Discover, ☐American Express_____

Name on the card_____

Number_____Exp Date_____

3- or 4-digit code_____

☐Yes ☐No - I want a receipt emailed to me.

Email Address_____

Signature_____Date_____

Printed Name_____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**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
Add the score for each column	0	0	0	0

Total Score (add your column scores): 0

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over 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's 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
Add the score for each column	0	0	0	0

Total Score (add your column scores): 0

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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