Psychiatric Specialists of Texas (PSOT)
5440 Old Brownsville Road
Corpus Christi, TX, 78417-9765
Ph 361-452-1151 | Fax 361-452-1517
http://www.psotcc.com

Dear Applicant:

Thank you for your interest in becoming a patient at the Psychiatric Specialists of Texas (PSOT). In order to provide you with the best care, it is important for our medical team to have the information requested in the following pages of the Health History.

Complete **ONLY** the individual sections where there is a current or recent concern.

We look forward to having the opportunity to serve you. If you need assistance with completing the Health History, or if you have any questions, please contact us at (361) 452-1151.

Please submit the completed Form by mailing / faxing to:

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**Electronic Communication:** If you would like to use email communication, please provide your email address. Please note that we cannot send private medical information by email due to privacy concerns. If the patient is a minor, please list the email address of the parent/legal guardian.

**Email Address:** _____@_____

Patient
Parent/Guardian

**How did you hear about PSOT?**

Family Member┤Friend
Internet - *if so*:
Professional Referral *(please provide specific information on the next page)*

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# Psychiatric Services OF South Texas
## Informed Consent and Assignment of Benefits

**Patient's Name:** _____

**Introduction:** Psychiatric Specialists of Texas (PSOT) is a professional association that provides psychiatric services primarily to children and adolescents. Each patient's treatment will be individualized to his or her needs.

The professionals who are members of the team working with PSOT and who may serve the patient are physician assistants and nurse practitioners. A summary of qualifications of those individuals will be provided upon request. Any questions or concerns regarding professional services provided under PSOT may be discussed with any member of our professional team.

**Fees:** All fees are billed to the appropriate insurance provider shortly after services are provided. Fees cover evaluations, assessments, individual therapy, and family therapy as needed. Your insurance provider will send a statement, an Explanation of Benefits, of all of our services.

**Confidentiality:** Information about the resident is kept confidential in accordance with our privacy policy and requirements by the Health Insurance Portability and Accountability Act (HIPAA). Medical, legal, billing and ethical requirements specify certain conditions when it is necessary to share information about the patient with other professionals. The patient's insurance provider sometimes requests clinical information to support payment. Insurance companies are responsible for keeping this information confidential just as we are.

**Consent to Photograph:** I hereby authorize the office of PSOT to photograph the patient for identification purposes and for quality assurance purposes.

**Assignment of Benefits:** My right to payment for all procedures and services including major medical benefits are hereby assigned to PSOT. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. In the event my insurance carrier does not accept assignment of benefits or, if payment is made directly to my representative or me, I will endorse such payments to PSOT. I understand that I am responsible for any charge not reimbursed by Medicare or other insurance coverage that is in effect. I authorize Medicare or any other insurance carrier to release my personal data and any information regarding my coverage to PSOT. I also authorize agents of any hospital, nursing home, long-term care facility or previous psychiatrists or psychologists to furnish PSOT copies of any records of my medical history, services, and/or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of audits and quality assurance reviews within PSOT.

**I have read this document and understand the information contained in it. I understand that this informed consent and assignment of benefits will remain in effect unless revoked by me in writing.**

Patient /Family member notified and/or signed _____

☐ Self ☐ Guardian ☐ POA ☐ RP Date: _____

**Office use only:**

_____Patient's Initial

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## POLICIES:

### General:

- Minor patients (under17 y/o) must be accompanied by the parent or guardian for all appointments.
- Office hours are Monday through Friday, 9:00AM-5:00PM.
- Patients are seen by appointments only except Wednesdays and Fridays 11:00AM-2:00PM which is our walk-in clinic hours for established patients.
- If New Patient paperwork has not been completed prior to appointment please arrive 30 minutes prior to appointment.
- Late patient arrival may require rescheduling.
- This office has a zero-tolerance policy for any kind of harassment verbal or nonverbal.
- This office does not routinely prescribe Xanax.

### Medications:

- New patients are required to bring their current medications or a list thereof to the initial visit.
- Medication refills are not given to patients who do no keep their follow- up appointments.
- C II policy: Administrative processing of C II prescriptions may take 3-5 days.

### FEES:

- Patients with a balance over $100.00 will have to be in office until balance is paid.
- Payment is required at the time of service. This includes co-pays, deductibles, and previous balances. (If any concerns please call the office at any time and speak to financial services/billing.
- Payment for services is the responsibility of the patient.
- We will not re-file claims if the patient has not updated their information.
- A list of fees are as follows:

➢ $25.00- Medical Records
➢ $30.00- Preparation of forms for FMLA, Disability, etc. (With 10 days advance to prep)
➢ $10.00- Diagnosis Letters

**No Show Policy: A $25.00 fee may apply for No Show Appointments**

_____ _____

Patient or Guarantor Signature Date

_____Patient's Initial

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**DEMOGRAPHICS:**
**PATIENT INFORMATION**

NAME: _____
Last, First Middle Initial

ADDRESS: _____

City: _____ State: _____ Zip Code: _____

DATE OF BIRTH: ____/____/_____ Social Security # _____ GENDER: ☐M ☐ F

Is the patient a minor? ☐Yes ☐No Is the patient the Guarantor? ☐ Yes ☐ No

Phone: (____) _____-_____
*(if different than Guarantor)*

***Complete the following information if the patient is a minor:***
*If parents are divorced indicate which parents has the right to determine medical care.*

Mother's Name: _____

Father's Name: _____ *or*

Legal Guardian's Name: _____ Relationship_____

**GUARANTOR INFORMATION (individual responsible for payment)**

NAME: _____
(Last, First, Middle Initial)

☐Patient ☐Parent ☐ Legal Guardian ☐Spouse ☐Other: _____

ADDRESS: _____
Number Street Apt.

City: _____ State: _____ Zip Code: _____

Home: (____) _____-_____ Work (____) _____-_____

Cell: (____) _____-_____; EMAIL: _____@_____

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**EMERGENCY CONTACTS**

NAME: _____

☐Parent ☐Legal Guardian ☐ Spouse ☐ Other: _____

PHONE: (_____) _____-_____

2. NAME: _____

☐Parent ☐Legal Guardian ☐ Spouse ☐ Other: _____

PHONE: (_____) _____-_____

**PROFESSIONAL REFERRAL:**

NAME: _____ PROF. TITLE: _____

Phone: (____) _____-_____

**COPY OF PHOTO ID AND INSURANCE CARD** **Or complete below**

| | | | |
|---|---|---|---|
| Medicare? | ☐ Yes | ☐ No | |
| Medicaid? | ☐ Yes | ☐ No | |
| TRICARE? | ☐ Yes | ☐ No | |
| Star Plus? | ☐ Yes | ☐ No | Plan: _____ |
| Other? | ☐ Yes | ☐ No | |

Member ID: _____ Group: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: -_____

Phone: _____

**FINANCIAL RESPONSIBILITY**

I understand that all professional services are charged to the patient, and are due and payable on the date that services are rendered unless other arrangements have been made in advance with the financial counselor.
I agree to pay all such charges in full immediately upon presentation of the appropriate statement.

Signed: _____ Date: ____/____/_____

_____Patient's Initial

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## PATIENT PSYCHIATRIC HISTORY FORM

**Purpose of Visit:** **Important Please Complete**

### Additional Information

Sleep: _____ hours/night: ☐Nightmares ☐ Onset insomnia ☐ Middle Insomnia ☐ Early Insomnia

**Please check all that apply:**

☐Sadness ☐Fatigue ☐ Withdrawal / Decrease Socialization ☐Thoughts of Hurting Self

☐Racing Thoughts ☐Irritability ☐Anxiety

☐ Attention Deficit Hyperactivity ☐Behavioral Problems ☐Impulsivity ☐ Unpredictable dangerous behavior

☐ General Overwhelming Stress ☐Hallucinations

☐ Anything you feel is important

### PSYCHIATRIC HISTORY

Have you ever seen a specialist/psychiatrist? ☐Yes ☐ No If yes, please fill in below:

| Name of Physician / Clinic | Duration of Treatment | Location (City / State) | Reason for Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you ever seen a primary care doctor for mood issues? ☐Yes ☐No

If so, please explain when and for what reason: _____

**Have you ever been hospitalized in a psychiatric facility?** ☐Yes ☐No If so, please fill below:

| **Name of Physician / Clinic** | **Duration of Treatment** | **Location (City / State)** | **Reason for Treatment** |
|---|---|---|---|
| | | | |
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**CURRENT MEDICATIONS**

**Pharmacy:**

**Drug allergies:** Yes No

What reaction did you have? _____

Please list any medications that you are now taking. Include non-prescription medications and vitamins or supplements:

| Medication (Brand/Generic Name) | Dose | Type (Liquid, Tablet, Capsule, Injection) | Frequency | Reason for taking | Date Started | Physician |
|---|---|---|---|---|---|---|
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**Helpful Information – Do your best – May leave blanks**

**Place of Birth**:_____ **Where raised:**_____

**Family Structure**:

Two Parent family Yes____No_____ If no explain_____

Siblings: ____ Brother(s)____Sister(s)_____

½ Siblings Mother_____ Father_____ Step-Sibs Mother_____ Father _____

**School:** Highest Grade _____Other Education_____

Degrees/Certificates: _____

**Religious Preference** _____ Cultural **Identification:** Anglo Hispanic Black Other

**Employment History**

Occupation_____

Disabled Yes No Year_____Reason for disability_____

**Sexual Identification** (circle) Heterosexual Undeclared Homosexual Bisexual Transgender

(Circle) Single Married Divorced Widowed

Number of Marriages_____Number of Significant Relationship_____Number of Children_____

**Legal:** any arrest/convictions Yes No If Yes explain_____

**Living Situation**: (Family composition):

_____

**Military Service:** None or Yes Branch and years of service_____

**Family History of Mental Illness**: ☐Negative ☐Positive ☐Unavailable

**Mother's Side:** _____

_____

i.e. Siblings, Grandparents, Aunts, Uncles, Cousins

**Father's Side:** _____

_____

i.e. Siblings, Grandparents, Aunts, Uncles, Cousins

_____Patient's Initial

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**History of Symptoms**

Yes No **Abuse Assault** if yes Yes No As Child Yes No As Adult

Yes No **Trauma Stress Disorders** Yes No **PTSD** Age of onset Frequency Flashbacks Nightmares

Yes No **ADHD**: IF yes Age of onset symptoms treatment controlled uncontrolled

Yes No Autism **Pervasive Developmental Diagnoses**

Testing done:

Yes No **Anger Problems** Age of onset Caused by Frequency Violent Behavior Educational Social Situations Occupational Marital Legal

Yes No **Oppositional Defiant Problems**

Yes No **Anxiety** If yes explain: Age of onset Triggers/Precipitating Factor(s) Episodes per week, month, year Treatment Last Episode

Yes No **Depression** if yes explain Age of onset Precipitating Factor(s) Episodes per week, month, year Any Treatment

Yes No **Memory Problems** If yes, recent memory long term memory forgetful miss appointments forget to pay bills

Yes No **Bipolar Disorder** if yes explain : Age of onset of symptoms Precipitating Factor(s) Episodes per week, month, year

BP/Mania

BP/Depression

Sucide ideation Suicidal Attempt(s)

Yes No **Eating Issues:** if yes age of onset symptoms episodes treatment

Yes No **Obsessive Compulsive Thoughts or Actions** if yes explain age of onset; symptoms; episodes; treatment;

Yes No **Hallucinations or Delusions** if yes age of onset; symptoms; treatment;

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**Chemical Use History:** Have you ever:

Yes No Used Nicotine: Smoke and/or Vape **if yes explain age started; age quit; amount used daily**

_____

Yes No Used Alcohol if **yes explain age started; age quit; amount used daily**

_____

Yes No Used Recreational Drugs **if yes explain age started; age quit; amount used daily for drugs used**

Marijuana_____

Cocaine _____

Methamphetamine _____

Heroin _____

Other i.e., Prescription rugs_____

LSD; PCP, Whip; Synthetic Marijuana; inhalant etc. _____

Yes No Do you receive Methadone?

Yes No Do you receive Suboxone?

Please complete the following forms if applicable

Non-Custodial Parent Form (If it is child under 18 and you share custody of the child)

Teachers Evaluation Form if you suspect your child has Hyperactivity of Inattentive Disorder)

Controlled Substance Contract if you are taking or think you will be prescribed a controlled substance.

Is there anything else we should know about you?