



# Progressive Behavioral HEALTH

Phone: 1-844-824-8775

Fax: 281-648-2200

[Pbhfront@progressivebehavioralhealth.com](mailto:Pbhfront@progressivebehavioralhealth.com)

Location: \_\_\_\_\_

### PATIENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Suffix (Circle): Jr. Sr. III IV Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
 Parent/Legal Guardian Name (If Applicable): \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Separated  Widowed SSN: \_\_\_\_\_  
 Spouse Name: \_\_\_\_\_ Spouse Number: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Mobile Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ \*Email: \_\_\_\_\_  
 \*An email address is required to access our patient portal.

### EMERGENCY CONTACT

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Mobile Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

### PATIENT EMPLOYMENT/SCHOOL DETAILS

Employment Status:  Full-Time  Part-Time  Not Employed  Self-Employed  Military  
 Employer Name: \_\_\_\_\_ Work: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Student Status:  Full-Time  Part-Time  Not a Student School Name: \_\_\_\_\_

### REFERRAL AND PHARMACY INFORMATION

Referring Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  
 Physician Referral: \_\_\_ Google: \_\_\_ Social Media: \_\_\_ Friend/Family: \_\_\_ Other: \_\_\_\_\_

Please let us know which pharmacy you prefer:

Walgreens  CVS  HEB  Kroger  Target  Sam's Club  Walmart  Other: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Mail Order Pharmacy:  CVS Caremark  Express Scripts  Prime Mail  Other: \_\_\_\_\_



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**FINANCIAL RESPONSIBILITY**

Primary Insurance Name: _____	Behavioral Health Phone Number: _____
Policy Number: _____	Group Number: _____
Insurance Claims Address (Back of Card): _____	
Policy Holder Name: <input type="checkbox"/> Self	Full Name/Relationship: _____
Policy Holder DOB: ____/____/____	
Secondary Insurance Name: _____	Behavioral Health Phone Number: _____
Policy Number: _____	Group Number: _____

**INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT**

I certify that I have insurance coverage with the primary insurance company and the second insurance payer, if applicable, listed above. I assign directly to Progressive Behavioral Health, PLLC all insurance payments, if any otherwise payable to me for services rendered. I understand I am financially responsible for any deductible, co-insurance, copayment, non-covered charges, and any balances not covered under a signature for all insurance submissions. I understand that it is my responsibility to pay for any services rendered at the time of visit.

**FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT**

Payment for services rendered is the responsibility of the patient, parent, or guardian. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage on your behalf. *However, you are ultimately responsible for the payment of your bill, regardless of insurance coverage.* Once insurance claims have processed, any remaining balance(s) will be billed to the patient. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan, administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. Progressive Behavioral Health, PLLC and its associates are not parties to that contract and cannot act as a mediator with the carrier or employer. The patient will become responsible for complete payment to the provider if coverage has terminated due to lack of premium payment.

As required by insurance mandates, it is the responsibility of the patient to obtain any necessary authorization for medical treatments. If a referral is required for treatment, it is the responsibility of the patient to obtain the referral and present it at the time of treatment. If the patient is treated without the proper referral or authorization as required by the insurance carrier, the patient assumes responsibility for payment of all fees at the time of service.

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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**Medication Reconciliation Form**

I, \_\_\_\_\_, am a patient of Progressive Behavioral Health (PBH), PLLC. The following is a list of all my prescribed and non-prescribed medications from all my other healthcare providers. I understand that my treatment at PBH will rely on this information to make appropriate treatment decisions and it is my responsibility to ensure that this information is accurate. I will also make sure that I regularly update this information, if there are any future changes in these medications.

Prescribed Medication(s):

Prescriber:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OVER THE COUNTER MEDICATIONS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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HEALTH

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**CONSENT FOR OFFICE POLICIES AND PROCEDURES**

Progressive Behavioral Health, PLLC is dedicated to providing excellent behavioral health services and treating patients with dignity and respect. Below are our office policies and conditions of care:

*Please initial below where indicated as acknowledgement and consent of all office policies and procedures:*

Patient  
Initials

\_\_\_ **Emergency Calls:** For after hour emergencies, please call 911 or go to the nearest emergency room. Patients can call 1-844-824-8775 and leave a message for non-emergencies only. All messages will be addressed as soon as they are received and processed by our office staff. If you need to speak with the physician, calls will be returned based on clinical issues that need to be discussed and physician's availability.

\_\_\_ **Non-Emergency Calls:** A \$65 charge will apply for any non-emergency calls made by providers.

\_\_\_ **Billing Policy:** PBH will bill your insurance, on your behalf; provided we are contracted with your insurance company and you are not a private pay patient. The responsible party agrees to provide all insurance information, at or prior to the first appointment. The responsible party also agrees to notify PBH of any changes in insurance coverage within 10 days and is responsible for all charges not covered or not paid by the insurance for any reason.

\_\_\_ Co-payments, deductible & any fees not paid by the insurance are due at the time of service.

\_\_\_ Any returned check from the bank is subject to a \$30.00 processing fee.

\_\_\_ Written court reports, copying of records and legal work may be subject to an additional charge.

- A \$25 charge for the first 25 pages and \$0.25 per page, thereafter, will apply for all copies of medical records.
- A charge of \$200 per hour will apply for ALL completed disability/FMLA paperwork and will be completed at the discretion of the provider only.
- Our regular physician hourly charge for any other work, not covered by insurance is also \$200 per hour.

\_\_\_ **Appointment Cancellation:** There is a 48-hour cancellation policy for all appointments. A \$150 fee will be applied to the patient's account for any late cancellations/no-shows as insurance does not cover these fees/charges.

\_\_\_ **Active Patient:** You will automatically be considered inactive after two missed appointments without notice or passage of two months without an appointment, with no reply to office contact attempts.

\_\_\_ **Termination of Treatment:** Treatment can be terminated if treatment is not progressing as expected or there is lack of expected clinical improvement for any reason; failure to follow the recommended treatment plan; delinquent payments; failure to keep the scheduled appointments as per office policies.

\_\_\_ **Privacy Policy Notice:** I acknowledge that I have reviewed a copy of the Notice of Privacy Practices (All documents are available for review at front desk.).

\_\_\_ **Office Policies and Procedures Notice:** I acknowledge that I have reviewed a copy of the Office Policies and Procedures, Prescriptions and Refills Policies and the Controlled Substances Agreement (All documents are available for review at front desk.).

I hereby authorize PBH to conduct an evaluation and perform treatment for myself and/or my dependents with regards to psychiatric or behavioral problems. I have read and understand the above office policies and agree with these policies.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient or Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## CONSENT FOR RELEASE OF INFORMATION/HEALTH CARE COORDINATION FORM

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security Number: \_\_\_ - \_\_\_ - \_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

I hereby authorize Progressive Behavioral Health, PLLC to release/receive the following health information:

- |                                       |   |
|---------------------------------------|---|
| _____ Initial Evaluation/Assessment   | _____ Psychological Reports & Testing Results |
| _____ Medical History and Information | _____ Laboratory Results/Reports              |
| _____ Psychotherapy Notes             | _____ Billing Records/Information             |
| _____ Office Visit/Progress Notes     | _____ Transfer/Discharge Summary              |
| _____ Complete Medical Record         | _____ Other: _____                            |

Please release the requested information for these treatment dates: \_\_\_\_\_

Records to be released to:

Records to be requested/received from:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Health Care Provider Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I acknowledge that I have the right to revoke this authorization in writing at any time by sending such written notification to the releasing person/agency. I understand that my revocation will not be effective to the extent that PBH has already taken action in reliance of this authorization or if this authorization was obtained as a condition of, obtaining insurance coverage and the insurer has the legal right to contest the claim. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be required as indicated in the copy of the Notice of Privacy Practices of Progressive Behavioral Health, PLLC., that I have received and reviewed. I acknowledge that the authorized recipient may accomplish the re-disclosure of my protected health information and that Federal Privacy Rule will no longer protect it. I acknowledge and understand that I am waiving my right to confidentiality with respect to the information or records released pursuant to this consent and I hereby release Progressive Behavioral Health, PLLC and its staff from any and all liability arising from the release and disclosure of the information or records. A photocopy or fax of this authorization is as valid as the original. **Please note: This authorization will automatically expire one year from signing unless other date of expiration is specified here:** \_\_\_\_\_

I acknowledge that I have read this authorization for release of information in its entirety and I fully understand its terms and implications. I freely, voluntarily and without and coercion, agree with the terms and conditions contained in this authorization.

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_





**CONTROLLED SUBSTANCES AGREEMENT**

**(Please read carefully and sign for your medical record. A copy will be given to you upon request.)**

I will use my medication(s) exactly as directed by my provider.

I will not allow or assist in the misuse/diversion of my medication(s); nor will I give or sell them to anyone else. All medication(s) will be obtained at one pharmacy, where possible. Should the need to change pharmacies arise, I will inform my provider immediately. I will use only one pharmacy and I will provide my pharmacist a copy of this form. I authorize my provider to release my medical records to my pharmacist as needed.

I understand that my prescription(s) and my medication(s) are specific to my plan of care. If my medications are either lost or stolen, replacement prescriptions may be given only with the proper documentation and will be done at the sole discretion of my provider(s). Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) may be allowed when I am traveling and arrangements are made with my provider(s) in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.

I will receive medication(s) only from ONE provider unless it is for an emergency or my provider approves the medication that be prescribed by another provider. Information that I have been receiving medication(s) prescribed by other providers that is not been approved by my provider may lead to a discontinuation of medication(s) and treatment.

If it appears to my provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my provider may try alternative medication(s) or may taper me off all medication(s). I understand that discontinuation of medications may cause withdrawal symptoms.

I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without warning. If I test positive for illegal substance(s), such as marijuana, cocaine, etc., this controlled substance treatment ~~can~~ may be terminated.

I agree that I will inform any provider who may treat me for any other medical problem(s) that I am taking controlled substances, as the addition of other medication(s) may cause harm to me.

I will take the medication(s) as instructed by my provider. Any unauthorized change in the dose of medication(s) will be viewed as a cause for discontinuation of the treatment.

I will keep all follow-up appointments as recommended by my provider or my treatment may be discontinued.

I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this form while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## Informed Consent for Telehealth-Based Healthcare Services

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Practitioner Name \_\_\_\_\_ Date Consent Discussed \_\_\_\_\_

### Introduction

Progressive Behavioral Health practitioners often use of Telehealth and related technologies to facilitate the delivery of healthcare services. Telehealth involves the use of electronic communications to enable health care providers and patients at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include psychiatrists, psychologist, nurse practitioners, therapists, primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may, but not necessarily, include any of the following: medical images, instant messaging, chat, telephone and/or email conversations, patient medical records, live two-way audio and video, and output data from medical devices and sound and video files.

### Expected Benefits

- Improved access to medical care by enabling a patient to remain at a remote site while the practitioner obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation, treatment and management.
- Obtaining expertise of a distant specialist.

### Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the practitioner.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. In the event that there is an equipment or technological failure during a Telehealth encounter, you should call the following phone number for instructions from your practitioner on how to receive follow-up or ongoing care 1-844-824-8775.

In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- In the event of any adverse events or unexpected reaction to treatment that may occur during or after your Telehealth encounter, you should follow-up with your primary care physician or emergency room, if applicable, or you may call your practitioner at the following phone number 1-844-824-8775 for any non-urgent issues. Telephone calls will be returned within 72 hours.

### By signing this form, I understand the following:

1. I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment.



2. A variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My practitioner has explained the alternatives to my satisfaction.
3. My practitioner must clearly disclose his/her identity, including information such as the practitioner's name, address, contact information, and medical licensing credentials.
4. Progressive Behavioral Health will not allow any other people to observe or participate in the Telehealth encounter without my knowledge or advance consent.
5. Progressive Behavioral Health will not make recordings of any video or telephone encounters about me without my advance consent.
6. I may request a copy of my medical information and/or that my medical information be sent to my primary care provider or other health care provider, if applicable.
7. My practitioner must provide appropriate follow-up care or recommend follow-up care as necessary.
8. I have the right to know what personal data may be gathered about me and by whom.
9. I have been informed about when online communication should not take the place of a face-to-face interaction with a practitioner.
10. I have the right to be provided meaningful opportunities to give feedback about any concerns I may have about my care and that Progressive Behavioral Health must review and respond to those concerns in a timely and appropriate manner.
11. Progressive Behavioral Health must obtain my express consent before forwarding any of my identifiable information to a third party other than in accordance with HIPAA and other applicable laws.
12. I must verify my identity and location prior to initiating a Telehealth encounter.
13. Telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
14. I agree to hold harmless my Practitioner for delays in evaluation or for information lost due to such technical failures.
15. It is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other healthcare providers.
16. I may expect the anticipated benefits from the use of Telehealth in my care, but that no results can be guaranteed or assured.
17. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Patient Consent to The Use of Telehealth

I have read and understand the information provided above regarding Telehealth, have discussed it with my practitioner or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Telehealth in my medical care.

I hereby authorize Progressive Behavioral Health practitioners to use Telehealth in the course of my diagnosis and treatment.

Signature of Patient \_\_\_\_\_  
 (or person authorized to sign for patient)

Date \_\_\_\_\_

If authorized signer, relationship to patient \_\_\_\_\_

I have been offered a copy of this consent form \_\_\_\_\_  
 (patient's initials or authorized agent's initials)



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Location: \_\_\_\_\_

**PRE-AUTHORIZED USE OF CREDIT CARD**

DATE: \_\_\_\_\_

I authorize Progressive Behavioral Health, PLLC to keep my signature on file and to charge my credit card during my course of treatment at Progressive Behavioral Health, PLLC.

Charges include any payments that are patient responsibility including but not limited to: deductibles, copay, co-insurance and any non-covered or denied insurance payments.

Patient's Name: \_\_\_\_\_

Patient or Parent/Guardian  
signature: \_\_\_\_\_

I authorize Progressive Behavioral Health, PLLC to charge my credit card for any amount/fee owed to my credit card below.

Credit Card # \_\_\_\_\_

( ) Visa ( ) Mastercard ( ) Discover ( ) AMEX ( ) Other

Expiration Date: \_\_\_\_\_ CVV (3-digit security code): \_\_\_\_\_

Name on card: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_



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**Patient Treatment Contract**

I am a patient at Progressive Behavioral health, PLLC and voluntarily agree to this treatment contact as follows:

1. I agree to keep all appointments, and to be on time to them.
2. I agree to not sell, share or give any of my medications to another person. I understand that such mishandling of my medication is a serious violation to this agreement, and it would result in termination of treatment without any recourse for appeal.
3. I understand that if any illegal/disruptive activities are observed or suspected by employees of the pharmacy, they will be reported to PBH and could result in termination of treatment without any recourse for appeal.
4. I understand that my prescription refills will be provided at my regularly scheduled appointment. If I miss an appointment, I may not receive my prescription refill until the next scheduled appointment.
5. I understand that the prescribed medication is my responsibility. I agree to keep it safe and secure. I understand that if my medications are either lost or stolen, replacement prescriptions may be given with proper documentation and will be done at the sole discretion of my provider(s).
6. I agree not to obtain controlled medications from any other doctors, pharmacies or other sources without notifying my treating provider at PBH.
7. I agree to take my medication as my provider has instructed and not to alter the way I take my medication without first consulting with my provider.
8. I understand that medication alone is not sufficient treatment of my condition and I agree to participate in all other treatment modalities as discussed and specified in my treatment plan.
9. I agree to abstain from all addictive and/or illegal substances.
10. I agree to provide urine samples/drug screens and have my provider test my blood alcohol, and controlled substance levels as needed.
11. I understand that any violation of this contract may be grounds for termination of treatment.
12. I understand that a Nurse Practitioner will most likely manage my care under the supervision of an MD and an MD may not always be available to see me.

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_