Progressive Behavioral HEALTH

Phone: 1-844-824-8775
Fax: 281-648-2200
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: □ 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.

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Patient's 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
_____ Medical History and Information
_____ Psychotherapy Notes
_____ Office Visit/Progress Notes
_____ Complete Medical Record
_____ Psychological Reports & Testing Results
_____ Laboratory Results/Reports
_____ Billing Records/Information
_____ Transfer/Discharge Summary
_____ 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: _____

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PSYCHOTHERAPY SERVICE AGREEMENT

Welcome to Progressive Behavioral Health. This document contains important information about our professional services and business policies. When entering therapy, it is important to understand how services are delivered, and each person's role in the therapeutic relationship.
Therapy takes place in within healing relationship. The therapy partnership works due, in part, to clearly defined rights and responsibilities. There are also legal limitations to those rights.
Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. This is because the process of psychotherapy often requires reviewing unpleasant aspects of your experiences. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy work often leads to significant reduction in feelings of distress, and increased satisfaction in interpersonal relationships. There are no guarantees about what will happen on the journey. Psychotherapy requires a very active effort on your part. In order to enjoy the most success, you will have to work on what you learn in therapy during your time outside of the office.
The first 2 – 4 meetings involve a comprehensive evaluation of your needs and strengths. This will facilitate forming initial impressions of what to work on together. Next will be setting goals and creating a treatment plan. During the initial stages, you should make your own assessment of your comfort in working with your therapist. If you have any questions about your treatment, please let us know.

Appointments
Sessions will be 45 minutes, once per week, or as appropriate. Your appointment time is reserved for you. If you need to cancel or reschedule, we require 48-hour advance notice. Late cancellations or no-shows will incur a charge in the amount of $75. Please note that insurance companies do not provide reimbursement for cancelled sessions; thus, you would be responsible. Upon request, we would reschedule at the soonest. You are responsible for arriving on time for your session; if you are late, your appointment will still need to end on time. Please note the attached Consent for Office Policies and Procedures.

Insurance
Progressive Behavioral Health accepts most major insurances. Please see the attached Financial Responsibility form.

Professional Records
Progressive Behavioral Health manages health records in compliance with confidentiality standards. Please see the attached Notice of Privacy Practices and Authorization for Release of Information.
Except in unusual circumstances, you have the right to review your files. Because these are professional records, they could be misinterpreted and/or upsetting to untrained readers. For this reason, we would recommend your initial review with your therapist, or to have your records forwarded to another mental health professional to discuss with you. If we must deny access to your records, you have the right to have this decision reviewed by another mental health professional. As well, you have the right to request that a copy of your files be made available to any other health care provider upon your written release. Please see attached Authorization for Release of Information.

Confidentiality
While confidentiality in therapy is crucial to progress, there are notable exceptions to what can be kept private. Mental health professionals are mandated by law to report suspicions or incidents of abuse or neglect of

vulnerable community members. Please understand that therapists must report child or elder abuse or neglect concerns to the appropriate authorities.

Parents and Minors
Parental involvement can be key to work with minors. For children under age 14, consent is needed from the child up front to allow sharing necessary information with parents. For youth 14 and up, we need family agreement to permit disclosing general information about treatment progress and attendance. All other communication will require the youth's agreement, unless there is a safety concern that supersedes other considerations. In this case we make every effort to notify the youth of our intention to disclose information ahead of time, and to handle any objections.

Contacting the Therapist
Therapists are not readily available by phone due to the nature of their work. If you cannot reach the therapist, you may leave a confidential voicemail or text a message through our office's call center. Your call will be returned at the earliest, but it may take a day or two for non-urgent matters. If your circumstances do not allow waiting for the returned call, and you do not feel you can keep yourself safe, we urge you to call 911 and request to speak with a mental health worker. Alternatively, you could go to your nearest hospital emergency room for assistance.
Therapists make every attempt to inform you in advance of planned absences. They will seek to provide you will the name and number of a mental health professional covering the absence.

Other Rights
We value our clients, and any comment or concern will be taken seriously and handled respectfully. You have the right to request referral to another therapist, and you are always free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. We encourage you to ask any questions you may have about our services and our providers.

Consent to Psychotherapy
Your signature below indicates that you have read this Agreement and agree to the above terms.

_____
Client Full Name

_____ _____
Signature of client or personal representative 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, andthat 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 medicalinformation to other medical practitioners who may be located in other areas, including out ofstate.
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 interactionsregarding my care that I may have with other healthcare providers.
16. I may expect the anticipated benefits from the use of Telehealth in mycare, but that no results can be guaranteed or assured.
17. Electronic systems used will incorporate network and software security protocols to protect theconfidentiality of patient identification and imaging data and will include measures to safeguardthe data and to ensure its integrity against intentional or unintentional corruption.

<u>Patient Consent to The Use of Telehealth</u>

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 questionshave 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 useTelehealth in the course of my diagnosis and treatment.
Signature of Patient _____ Date _____
(or person authorized to sign for patient)

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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Location: _____

Authorization- Non-Parent/Guardian to Accompany Minor Child

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances, however we must have written authorization allowing this person to accompany your child(ren). In this case, the person bringing your child(ren) must be 18 years of age and will need to present a valid photo identification at the time service. This signed authorization gives the person permission to bring your child(ren) to appointments, speak to the doctor, give authorization for treatment, medication, schedule appointments and make general health decisions. I, _____ (legal parent/guardian) give the persons(s) listed below permission to bring my child to Progressive Behavioral Health, and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decision routine in nature as determined at the sole direction of the provider. I also give them authority to make more serious or urgent decisions where it is of an emergency nature, in the event I cannot be reached or where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____

Name of person allowed to bring child: _____

_____

_____

Parent/Guardian
Signature: _____ Date: _____