ALAMO MENTAL HEALTH GROUP
CHILD/ADOLESCENT INFORMATION RECORD

DATE: ________________________ CHART NO.:________________________

CHILD'S NAME: ____ SEX: ___________________
FIRST MIDDLE LAST

ADDRESS:____
STREET APT.# CITY STATE ZIP

HOME PHONE #: ______________________ ALTERNATE PHONE #: ______________________

DATE OF BIRTH: ________________AGE:__________ REFERRED BY: ______________________

CHILD'S SOCIAL SECURITY #: ______________________ **DRUG ALLERGIES:** ______________________

CURRENT MEDICATIONS:______________________ PARENT'S EMAIL:______________________

PRIMARY CARE PHYSICIAN:______________________ SCHOOL:________________GRADE:__________

FATHER'S NAME:______________________ D.O.B.:______________SSN: ______________________

ADDRESS:______________________ PHONE #:______________CELL PHONE # ________________

FATHER'S OCCUPATION:______________________EMPLOYER:______________WORK PHONE #: ______________

MOTHER'S NAME:______________________D.O.B.:______________SSN: ______________________

ADDRESS:______________________PHONE #:______________CELL PHONE # ________________

MOTHER'S OCCUPATION:______________________EMPLOYER:______________WORK PHONE #: ______________

EMERGENCY CONTACT: ______________________ PHONE NUMBER: ______________________

1. **PRIMARY INSURANCE CO. NAME**:______________________ EFFECTIVE DATE: ______________________

POLICY NO.: ______________________ GROUP NO.:______________________

NAME OF POLICY HOLDER: ______________________ RELATIONSHIP TO PATIENT:______________________

POLICY HOLDER'S SSN: ______________________ **POLICY HOLDER'S D.O.B.:** ______________________

2. **SECONDARY INSURANCE CO. NAME:**______________________ EFFECTIVE DATE: ______________________

POLICY NO.: ______________________ GROUP NO.:______________________

NAME OF POLICY HOLDER: ______________________ RELATIONSHIP TO PATIENT:______________________

POLICY HOLDER'S SSN: ______________________**POLICY HOLDER'S D.O.B.**:______________________

INSURANCE AUTHORIZATION: I hereby authorize the provider(s) from Alamo Mental Health Group to furnish information to my insurance carrier(s) concerning my dependent's illness and treatment.

ASSIGNMENT OF BENEFITS: I hereby assign the providers from Alamo Mental Health Group all payments for mental health services rendered to myself or my dependents. ***I understand that I am responsible for any amount not covered by insurance.***

STATEMENT OF FINANCIAL RESPONSIBILITY: I understand payment in full is expected at the time of service for office visits unless other arrangements have been made. Alamo Mental Health Group is responsible for providing documentation for me to submit to my insurance carrier for reimbursement. I understand co-payments and deductible payments for certain insurance companies are accepted in lieu of complete payment at the time of my visit. ***I understand if my insurance company fails to pay for any service rendered to my dependents or to me, I am financially responsible for payment.***

RESPONSIBLE PARTY: ____ **DATE:**____________________

ALAMO MENTAL HEALTH GROUP

SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES (*Effective Date: 4/14/03*)

Privacy Practices: We are required by law to follow the practices described below. This is a summary of our Privacy Practices, but does not replace the full version which will be made available to you upon request. This notice applies to personal medical/health information that we have about you, and which are kept in or by AMHG. With some exceptions, we must obtain your authorization to disclose (or release) your health care information There are some situations in which we do not have to obtain your authorization. Neither this summary nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact AMHG's Privacy Officer, Michael Castillo, Ph.D., at 614-8400, ext 302.

Medical/health information about you can be used to:

- Plan your treatment and services. This includes releasing information to qualified professionals who work at AMHG and are involved in your care or treatment. It may also include provider agencies whom we pay to provide services for you. We will only release as little as possible for them to do their jobs.
- Submit bills to your insurance, Medicaid, Medicare, or third party payers.
- Obtain approval in advance from your insurance company.
- Exchange information with Social Security, Employment Security, or Social Services.
- Measure our quality of services.
- Decide if we should offer more or fewer services to patients.

We may use your personal information without your permission:

- To make appointment reminders.
- To treat you in an emergency.
- To treat you when there is something that prevents us from communicating with you.
- To exchange information with other State agencies as required by law.
- To inform you about possible treatment options.
- For agencies involved in a disaster situation.
- For certain types of research.
- When there is a serious public health or safety threat to you or others.
- As required by State, Federal, or local law. This includes investigations, audits, inspections, and licensure.
- When ordered to do so by a court.
- To communicate with law enforcement if you are a victim of a crime, involved in a crime at our facility, or you have threatened to commit a crime.
- To communicate with coroners, medical examiners, and funeral homes when necessary for them to do their jobs.
- To communicate with federal officials involved in security activities authorized by law.
- To communicate with a correctional facility if you are an inmate.

You have the right:

- To see and get a copy of your record (with some exceptions).
- To appeal if we decide not to let you see all or some parts of your record.
- To ask for the record to be changed if you believe you see a mistake or something that is not complete. You must make this request in writing. We may deny your request if: We did not create the entry that is wrong; or the information is not part of the file we keep; or the information is not part of the file that we would let you see; or we believe the record is accurate and complete.
- To know to whom we have sent information about you for up to the last six years (beginning April 14, 2003). The first request in a 12 month period is free. We may charge you for additional requests.
- To limit how we use or disclose information about you. For example, not to release information to your spouse or a particular provider agency. (This must be made in writing, and we are not required to agree to the request).
- To ask that we communicate with you about medical matters in a certain way or at a certain location. This must be made in writing.
- To tell us (authorize) other releases of your personal information not described above. You may change your mind and remove the authorization at any time (in writing).
- To have a paper copy of the Notice of Privacy Practices.
- To file a complaint if you believe any of your rights have been violated. All complaints must be in writing. You will **not** be penalized if you file a complaint.

If you wish to exercise any of these rights, or to file a complaint, you should contact AMHG's Privacy Officer:
Michael Castillo, Ph.D., at 614-8400, ext. 302

ALAMO MENTAL HEALTH GROUP
OFFICE PRACTICES AND POLICIES

Welcome to Alamo Mental Health Group. To better serve our patients, we have developed the following guidelines. If you have any questions regarding office practices or policies, please ask your provider. If they are unable to answer your questions, they will refer you to the appropriate Alamo resource.

Business Hours: General office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. Early evening and Saturday appointments are available with some providers. Please check with your provider for his/her specific schedule.

Payment: Payment is expected at the time of arrival. Our contracts and agreements with insurance companies and health plans **require** us to collect all co-payments and deductible amounts at the time of service. If payment is not made at the time of the scheduled appointment, a **$10.00** administrative fee will be assessed. A **$30.00** fee will be assessed for all NSF checks.

Services: Alamo Mental Health Group offers a variety of services including individual psychotherapy, family therapy, group therapy, medication evaluations and medication management/follow-up appointments. Your provider will share with you a treatment plan with the recommended services for you and the recommended frequencies. Some of our providers also offer specialized services. Many health plans and insurance companies may not cover some services and do not provide benefits for the services. Services which may not be covered by your insurance company included, but are not limited to:

- disability evaluations	- smoking cessation	- treatment mandated by the court, or other third party
- custody evaluations	- marriage counseling	- educational/academic assessments
- pain management	- sex therapy	- court appearances/depositions

Please check with your insurance carrier regarding specific information on your particular health plan coverage.

Providers: Alamo Mental Health Group is staffed by a group of **independent contractors** who are licensed, qualified mental health professionals, providing a variety of services. You may see only one or several different mental health providers at Alamo Mental Health Group.

Psychiatrists are medical doctors and are available to prescribe medications. If you need to be evaluated for medications, a psychiatrist will see you for the evaluation. Psychiatrists may also work with other providers in evaluating the need and effects of medications. Psychiatrists do not typically provide psychotherapy or counseling.

Psychologists are Ph.D. and Psy.D. level practitioners who are not medical doctors. Psychologists provide individual, couples, group, and family therapy. Psychologists also perform psychological evaluations and testing.

Therapists are master level practitioners who are not medical doctors. Therapists provide group, individual, and family therapy.

Appointment Length: Services may be of varying lengths, depending on the service and nature of your problem. The following are guidelines:

Individual psychotherapy is generally 45 to 50 minutes, although some appointments may be 25 to 30 minutes
Group therapy is generally from 50 to 80 minutes
Family therapy is generally 45 to 50 minutes
Medication evaluations are generally 20 minutes to 50 minutes
Medication follow-up appointments are generally 15 minutes

Missed Appointments ("No Shows")/Cancellations: Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than **24-BUSINESS-hours** notice, you will be billed according to the scheduled fee and instructions of your benefit plan. It is the policy of Alamo Mental Health Group to charge a fee of **$150.00** for missed or canceled initial appointments with a psychiatrist and **$100.00** for any missed or late-canceled follow-up appointments with a psychiatrist with less than a **24-BUSINESS-hour** notice. There will also be charge of **$100.00** for any missed or late-canceled appointments with a psychologist or therapist. Your insurance company will not be billed for fees associated with missed or last minute canceled appointments.

You may cancel a scheduled appointment prior to **24-BUSINESS-hours** of your scheduled appointment by calling the office and speaking to a member of our administrative staff or by e-mailing us at cancelmyappointment@alamomentalhealth.com.

Patient Tardiness A patient arriving late for their scheduled appointment may not be able to be seen by their provider and may be considered a "no show."

Provider Cancellations: Occasionally your provider may need to change his/her schedule, cancel, and reschedule appointments with you. You will be informed of this as far in advance as possible and/or rescheduled. In the event of illness of your provider, we may unfortunately be forced to give you little or no notice regarding the absence and the need to reschedule your appointment.

Copies of Records: If you would like your physician or other professional to obtain a copy of your record, a release of information **must** be signed. The requesting party will be responsible for any fees. When applicable, the charge for records is **$25.00** for the first **20** pages and **.50** cents for each additional page after the first twenty. All fees must be paid in advance. It may take up to 15 business days to obtain a copy of your medical records once all fees are paid.

Court Appearances/ARD Meetings: A subpoena is required for **all** court appearances. The individual requesting the court appearance will be responsible for any fees charged. This also applies to depositions, other court related matters, and attendance at ARD meetings. Our charges for court/school related activities are generally greater than our typical charges for mental health services. The business office can provide more detail on this subject.

Disability Forms/Reports: There will be a **$25.00** charge for the first page and **$5.00** for each additional page for the completion of forms or reports for someone other than your health insurance. This charge must be paid in advance. If the form can be completed as part of your visit, there may be no charge. The business office can provide more information.

Emergencies: Alamo Mental Health Group has night and weekend coverage for **emergencies only**. We expect calls after 5:00 p.m. and on weekends to be for **emergencies only**. In the event of an emergency, you may call 614-8400 and have the on-call provider return your call and address your emergency.

Prescriptions: Prescriptions are generally written in a quantity to last until the next scheduled appointment. It is our policy not to refill prescriptions outside of scheduled appointments. If it does become necessary for a refill to be written or called in to your pharmacy due to you not keeping a scheduled appointment, a charge of **$20.00** may be assessed. A **$15.00** charge will be assessed on prescriptions of triplicate medications (such as Ritalin, Vyvanse, Adderall, and Concerta) that are written between scheduled appointments. A **$25.00** charge will be applied if a prescription must be rewritten due to the loss or expiration of that prescription. Requests for prescription refills are to be called in by your pharmacist from 9:00 a.m. through 3:00 p.m., Monday through Thursday for approval. A minimum of **five** business days is typically required for the prescription refill to be approved. Urgent prescription refills (less than five business days) can be issued for a **$25.00** fee. In general, prescription refills cannot be ordered or approved after business hours because your physician and chart may not be available.

Treatment Philosophy-Explanation of Treatment: Treatment at Alamo Mental Health Group is goal-directed and problem-focused. This means that your treatment goal or goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of the goal(s) in a time efficient manner. You are asked to take an active role in setting and achieving your treatment goals. Your commitment to this approach is necessary for you to experience a successful outcome. If you have any questions about the nature of your treatment or care, please do not hesitate to ask your provider.

Your Rights and Responsibilities:

1. You have the right to receive information about Alamo Mental Health Group's services and practitioners, clinical guidelines, and patients' rights and responsibilities.

2. You have the right to be treated with respect and recognition of your dignity and need for privacy.

3. You have the right to participate fully with your provider in decision-making regarding your treatment planning.

4. You have the right to voice complaints or appeals about Alamo Mental Health Group or the care provided to you.

5. You have the responsibility to provide, to the extent possible, information that AMHG and its providers need in order to care for you.

6. You have the responsibility to follow the plans and instructions for care that you have agreed upon with your provider.

7. You have the responsibility to participate, to the degree possible, in understanding your behavioral health problem(s) and developing mutually agreed upon treatment goals.

Patient Advocate: Should you have a complaint or comment about any Alamo Mental Health staff or your provider, please contact Michael Castillo, Ph.D., at 614-8400, ext 302.

ALAMO MENTAL HEALTH GROUP

MISSED APPOINTMENT OFFICE POLICY

Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than **24-BUSINESS-hours**, you will be charged for the time reserved. It is the policy of Alamo Mental Health Group to charge **$150** for a missed or late-cancelled initial assessment With a psychiatrist and **$100** for any missed or late-canceled follow-up appointments with a psychiatrist. There will also be a charge of **$100** assessed for **any** missed or late-canceled appointment (less than **24-BUSINESS-hours**) with a psychologist or therapist.

While we do attempt to provide a **"courtesy"** reminder call for scheduled appointments, it is the responsibility of each patient to arrive on time for their scheduled appointments.

We understand there may be extenuating circumstances that may result in your need to cancel an appointment, but, unfortunately this time has been reserved especially for you by your provider. We do not overbook and we need time to make the appointment time available to other patients should you need to cancel. Thus, your account will be charged, regardless of the .reason for the late or missed appointment. A statement will be emailed (or mailed if no email address is on file) to you notifying you of the charge.

Please note, appointments may be cancelled via the telephone or through our website. You may cancel a scheduled appointment prior to **24-BUSINESS-hours** by calling our office at (210) 614-8400 and speaking directly to a member of our administrative staff *or* by speaking to someone through our answering service. You may cancel an appointment by emailing Alamo Mental Health Group directly at *cancelmyappointment@alamomentalhealth.com*. By using our website to cancel an appointment, you will have confirmation verifying that the appointment was cancelled on time.

Please do not leave messages on voicemail. The time these messages are left cannot be confirmed and they will not be considered as appropriate notification for a cancellation.

Please provide an email address that can be used to send you a statement notifying you of the missed appointment charge. Also sign below indicating that you have read, understand, and agree to this policy.

Email Address that statements can be sent to: ____

Patient Name: ____ Date of Birth: ______________________

Responsible Party: ____ Date: ______________________

There are occasions that a patient makes an overpayment on their account due to incorrect deductibles or co-payments. On the occasion this does occur, a credit will be applied to your credit card. Please understand that if an underpayment is made and you owe money on your account, your credit card will **not** be charged. Instead, a statement will be mailed to you. This applied credit policy applies only when you have overpaid or when money is owed to you.

Please sign below if you have read, understand, and agree to this policy.

Responsible Party: ____ Date: ______________________

ALAMO MENTAL HEALTH GROUP
PRESCRIPTION REFILL POLICIES

Prescriptions are not usually refilled outside of scheduled appointments. Our doctors typically write prescriptions in quantities to last until the next scheduled appointment. It is your responsibility to make sure an appointment is scheduled in time to avoid a lapse in your medication. If there is a need for a refill to be called in between scheduled appointments, charges will be applied. Refill requests need to be called in by **your pharmacy**. A minimum of **5-BUSINESS-days** is required for the prescription to be approved. No prescriptions are approved on Fridays past the noon hour.

Insurance companies will often request prior approval for some medications. Certain medications require prior authorization (PA) or a medical exception for coverage. If this step is required, your doctor will have to request and receive approval from your insurance company before the medication will be covered under your insurance plan. This often results in a delay in obtaining the prescription. Please expect a **MINIMUM delay of three to five BUSINESS days**. Please be aware you can still have the pharmacy fill your prescription, but, it will not be covered by your insurance. Your prescription is still valid and you can pay for the medication out of pocket. Prior approvals may be minimized by bringing in your insurance co.'s drug lists or formulary to your scheduled appointment. If a medication is denied by your insurance, needs prior approval, or you find that a medication is too costly, you may need to schedule a follow-up visit with your provider to discuss other medication options.

Some insurance companies require your doctor to write "90-day prescriptions" once a medication is considered long term and is considered a "maintenance drug". If this happens, you will need to have your pharmacy send in a request. Please do not call our office. We will only respond to the request from a pharmacy.

There is a handling charge of **$20.00** for refills outside of scheduled appointments. Any prescription refills without a 5-day notice or any emergency refills will have a **$15.00** (for triplicate medications) or **$25.00** (for non-triplicate medications) charge applied. If a prescription is lost, there will also be a **$25.00** charge and the patient will be required to fill out the lost prescription form before the medication can be refilled. These charges are not billed to your insurance and are the patient's responsibility. Failure to keep regular office visits may result in denial of medication refills.

The State of Texas monitors "Triplicate medications" (such as Ritalin, Adderall, Concerta, Vyvanse, Dexedrine, & Focalin). Thus, **IF** a refill request is approved by your doctor, we must as that you adhere to the following guidelines:

1. You must call the doctor's office each month in order to receive your next refill. When requesting a Triplicate prescription, please provide – the patients full name, age, date of birth, address, and a telephone number where you can be contacted when the prescription is ready to be picked up.

2. Allow **5 days** for the doctor to pull the chart and verify the medication as we have numerous requests for these prescriptions each week. There will be a **$15.00** handling charge for refills outside of scheduled appointments. You may also have triplicate prescriptions mailed to you. They will be sent via certified mail, which may cost you **$3.00**.

3. You will be contacted when your prescription is ready. State law requires that it must be filled within 21 days from the date that is written on the prescription. If it expires, the outdated prescription must be returned to the office, and you may be charged a **$15.00** rewrite fee. If a prescription is lost, there will also be a **$25.00** charge and the patient will be required to fill out the lost prescription form before the medication can be refilled.

Finally, we would like to be sure we have the correct pharmacy information in our computer system. Please complete the information below and sign to show you have read and understand the above information.

PATIENT NAME:____ DATE OF BIRTH:_______________

PATIENT/GUADIAN SIGNATURE:____ DATE:_________________

NAME OF PHARMACY: ____

PHONE NUMBER OF PHARMACY:____

ZIP CODE OF PHARMACY:_____________________

ALAMO MENTAL HEALTH GROUP
ACKNOWLEDGMENT SHEET AND CONSENT FOR TREATMENT

I have received, read, and understand the policies of Alamo Mental Health Group including, the following information:

- Business hours, types and length of services, and providers
- Policies on payments and co-payments
- Scheduling policies
- Cancellation policies and procedures
- Policies on no shows and missed appointments
- Procedures for emergency services and telephone numbers
- Policies on prescription refills
- My rights and responsibilities
- **Notice of Privacy Practices, with an Effective Date of April 14, 2003**

Initial here:____________________

CONSENT FOR TREATMENT

I authorize and request my provider to carry out evaluations, treatment and/or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that I may terminate treatment at any time. While the course of treatment is designed to be helpful, I understand that there is no assurance that I will feel better and my provider can make no guarantees about the outcome of my treatment. Because treatment is a cooperative effort between me and my provider, I will work with my provider in a cooperative manner to resolve my difficulties. I understand that during the course of my treatment, material may be discussed which may be upsetting in nature and that may be necessary to resolve my problem(s).

____ ____

Patient Name Patient Chart Number

____ ____

Patient/Guardian Signature Date

GENERAL CONSENT FOR *CHILD OR DEPENDENT* TREATMENT

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize AMHG and its providers to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

____ ____

Patient Name Patient Chart Number

____ ____

Signature of Legal Guardian/Legal Representative Date

Alamo Mental Health Group
Authorization for Release of Confidential Information
4242 Medical Dr., Ste. 6300, San Antonio, TX. 78229
Phone: (210) 614-8400 Fax: (210) 614-8165

Patient Name: ____DOB: ________________________

SS#: ______________________________

1. I authorize _________________________/Alamo Mental Health Group to disclose the following health information about me:

_____ All Information/Records _____ Progress Notes _____ Billing Records

_____ Evaluation/Consultation Reports _____ Other __________________________________

2. The information to be disclosed is from_________________ to ____present/______________ (dates).

3. This information may be disclosed to (please give name and address of recipient):

Name: _______________________________ Name: _______________________________

Address: _______________________________ Address: _______________________________

_______________________________ _______________________________

Phn/Fax: _______________________________ Phn/Fax: _______________________________

4. This information may be disclosed for the purpose of:

_____ Coordination of Care _____ Assistance/Support of Treatment

_____ Other ____

5. The information may be disclosed until (ending date) ____________________. If this date is left blank, the authorization will automatically expire one year from the date I sign below.

6. I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore I release Alamo Mental Health Group, its providers and staff from all liability arising from the disclosure of my Health information.

7. I understand that I may inspect or request copies of any information disclosed by this authorization.

8. I understand that I may revoke this authorization by notifying, in writing, AMHG/____________________ except to the extent that action has already been taken on it.

9. I understand that I may decline to give authorization and that declining authorization to release information will not affect my ability to obtain treatment, payment, or my eligibility for benefits from AMHG.

10. ________ I **decline** to give authorization to release information at this time.

____ ______________________________

Patient Signature Date

____ ______________________________

Guardian Signature if appropriate Relationship to Patient