ALAMO MENTAL HEALTH GROUP
UPDATE TO PATIENT INFORMATION RECORD

DATE: ___________________ CHART NO.:_________________________

PATIENT NAME: ____ DOB: ____________________

1. Please provide us with any updates to your information below:

ADDRESS: ____

HOME PHONE: ____________________WORK PHONE: ___________________CELL PHONE: ___________________

EMAIL ADDRESS: _______________________________EMERGENCY CONTACT & NUMBER: ___________________

ADDITIONAL CHANGES IN DEMOGRAPHIC INFORMATION:____

________ THERE HAVE BEEN NO CHANGES IN MY DEMOGRAPHIC INFORMATION SINCE MY LAST UPDATE.

2. Please provide us with any updates to your primary insurance coverage since your last visit:

NEW 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.: ____________________

________ THERE HAVE BEEN NO CHANGES TO MY INSURANCE COVERAGE SINCE MY LAST UPDATE.

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.***

SIGNATURE: ____ DATE: _________________.

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 PPO's, HMO's, and Tricare 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: ______________.

AUTHORIZATION FOR RELEASE OF INFORMATION (PHI)

1. I authorize ____to disclose the following health information about me:

______Medical Information/Records ______Mental Health Treatment Records ______Progress Note/Reports,

______Psychological Reports ______Alcohol/Drug Information ______Consultation Reports,

______Other____

2. The information to be disclosed is from___________________________ to ______ present/________________(dates).

3. This information may be disclosed to: ____

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

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 **decline** to give authorization to release information at this time.

____ ______________________________________

Client Signature Date

____ ______________________________________

Signature of Person Informing Client of Rights Date

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:_____________________