FAMILY PSYCHIATRY OF THE WOODLANDS, P.A.
PATIENT INFORMATION

PATIENT NAME_____ BIRTHDATE_____
First Middle Initial Last

PATIENT SEX: _____Male _____ Female PATIENT SSN_____

HOME ADDRESS_____ CITY/STATE_____ ZIP CODE_____
HOME PHONE # _____ CELL PHONE #_____

If patient is a minor:
RESPONSIBLE PARTY NAME _____ REL TO PT _____
PHONE # (_____) _____ ADDRESS _____
CITY/STATE_____ ZIP CODE_____
EMPLOYER _____ PHONE #_____

PRIMARY INS. _____ INSURED NAME _____
PHONE #_____ REL TO PT_____ BIRTHDATE_____
SOCIAL SECURITY NO._____ GROUP NUMBER/PLAN_____
EMPLOYER NAME: _____

NOTE: Please complete the following section ***only*** if you want communications regarding your health care information or billing sent to an alternate address other than your residence.

_____
(Address) (City) (State) (Zip Code)

A COPY OF YOUR DRIVERS LICENSE and INSURANCE CARD IS REQUIRED
PAYMENT FOR SERVICES RENDERED IS DUE PRIOR TO TREATMENT
Effective 7/16/08; Revised 07/25/2016

All reasonable requests for confidential handling of your health information by alternative means will be granted:

- May we leave a message on your home answering machine? Y___ N____ Cell Phone Y___ N___
- Do you have an alternate phone number we may use? Y___ N____ Phone # _____
- Emergency Contact Name _____Relationship_____
  Phone Number _____
- May we share information regarding appointments or billing inquiries only with your spouse or an immediate family member? Y___ N___ Names: _____
- If the patient is a Minor, are biological parents: married ____ never married____ divorced ____.
- Minor Child Treatment Information may be shared with Non-Custodial Parent (if not specified otherwise in the court order) **Y__ N __**
  Non-Custodial Parent Name: _____

ATTENTION DIVORCED PARENTS OF MINOR CHILDREN: Please be advised you will need to provide Family Psychiatry of The Woodlands (*your provider*) with a court recorded/judge signed copy of your final divorce decree with cause number located on each page. This is to verify which parent has mental health/psychological rights to the minor child's treatment. **A minor child will not be seen if we are not supplied with the divorce decree. NO EXCEPTIONS!** If the mental health/psychological rights have been modified in a modification order, you will need to bring both copies to the minor child's appointment, original divorce decree and original modification order. Again, both orders must be filed with the court and have a cause number for verification purposes. (***Attorney's initial court filing copies will not be accepted.***)

IF YOUR CHILD IS ADOPTED: You will need to provide us a copy of court recorded/judge signed adoption papers with cause number located on each page. This is to verify that the child is legally in your custody.

Custody disputes and lawsuits: Our providers will not appear in court for custody cases to determine parental rights. However, we may respond to a subpoena in the form of printed medical records.

We understand that the above can be a burden. However it is in everyone's best interest that we follow the law in regards to which parent has mental health/psychological rights to the child.

Family Psychiatry of The Woodlands, P.A.
Effective 7/16/08; Revised 07/25/2016

We are committed to providing our patients with the best possible care and we are pleased to discuss our professional services with you at any time. Your clear understanding of our Office Procedures and Financial Policies is very important. All patients must complete our "Patient Information Form" before seeing a Professional/Provider.

Payment of services is handled prior to your session at the time of service. We accept cash, Visa, MasterCard, Discover, American Express, and Debit. Your insurance company mandates you must pay your co-payment at the time of service. If you cannot pay, you may be asked to reschedule. PERSONAL/BUSINESS CHECKS ARE NOT ACCEPTED.

NO SHOW/MISSED APPOINTMENT: We do charge a fee of $50.00 for missed/cancelled appointments, unless you notify our office 24 hours in advance, or have an emergency. Our policy is to charge $50.00 for medication management appointments or new patient appointments, and $65.55 for missed/cancelled therapy sessions. Please do not rely on the reminder calls, as this is a courtesy. Having 3 or more No shows or cancellation of appointments can result in termination of treatment as this is considered to be non-compliant with a Providers Treatment Plan. If you feel you were charged in error, please discuss this matter with our Practice Manager.
TARDY/LATE TO APPOINTMENT: You may be asked to reschedule if you are more than **15 minutes** late for your appointment.
INCLEMENT WEATHER: Check the website for office closings. We will not call you to cancel your appointment due to inclement weather. You will need to call and reschedule any untimely cancelled appointment due to inclement weather.
PROVIDER CANCELLATIONS: Provider's may cancel your appointment due to emergency situations that arise. The office staff will contact you when this happens and move your appointment to the next available appointment.

LETTERS AND FORMS: We charge a service fee for certain forms and/or letters that must be completed for a patient.

Childcare is not provided for children. Please do not leave children unattended in the reception area or in parked cars in the parking lot.

REGARDING INSURANCE ASSIGNMENT

We will only file claims with insurance companies we are contracted with. In order to achieve this, we must have all current insurance information on file.

If there are any changes in your insurance coverage, you must notify our Business Office 5 days prior to your next appointment or the visit will be self-pay or rescheduled. THIS IS YOUR RESPONSIBILITY.

The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company, is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. Therefore, any amount we collect at the time of service or quote as your responsibility is an estimate only. **You are ultimately responsible for any and all balances on your account.**

By signing below I acknowledge that I have read and understand the financial policies of Family Psychiatry of The Woodlands:

_____ _____
Patient/Guardian Signature ***Date***

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT:

___ Initial **ITEM 1 – FEMALE PATIENTS**
If taking medication I agree to notify ***Family Psychiatry of The Woodlands*** in the event that I am planning to become pregnant, or I become pregnant so that I may discuss the risks/benefits of medication.

___ Initial **ITEM 2 – ALCOHOL/DRUGS/HERBAL SUPPLEMENTS**
It is recommended not to use alcohol/drugs or herbal supplements in combination with prescription psychiatric medication and I agree to notify ***Family Psychiatry of The Woodlands*** if this is a concern.

___ Initial **ITEM 3 – MEDICATION REFILLS**
Medication is prescribed to last until your next appointment. You will need to make an appointment and be seen when medication refills are required.

___ Initial **ITEM 4 – LETTERS AND/OR FORMS**
There will be a charge for any forms and/or letters that must be completed in this office by any practitioner or office staff.

___ Initial **ITEM 5 – THERAPY SESSIONS**
Therapy sessions are scheduled for 45 minutes. In order for you to receive your entire session, please be prompt for your appointment.

___ Initial **ITEM 6 – CONFIDENTIALITY**
All information is guarded by strict confidentiality. We require your written consent in order to release / obtain information.

___ Initial **ITEM 7 – CONSENT FOR TREATMENT – CONSENT MUST BE SIGNED PRIOR TO THE START OF YOUR APPOINTMENT**
I hereby give consent for myself or the above named patient to be treated/tested by Family Psychiatry of The Woodlands, P.A. If the above named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court documents, that I have the legal right to request treatment for the above named minor. If you are **15-17 years of age,** you must co-sign. If you are **18 years of age,** you must sign yourself and are allowed the right to choose whether you wish anyone/parents to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co-joint therapy. A parent/guardian may not come in for an appointment without the patient. **The patient must be present at every visit. Patients under 18 years of age will only be seen with a parent or guardian present.**

___ Initial **ITEM 8 – TERMINATION OF TREATMENT**
Assault or verbally threatening behavior towards staff, other patients, or physical property of Family Psychiatry of The Woodlands, P.A. will be cause to terminate treatment and be held responsible for damages. Firearms and other weapons are prohibited, with exception for an officer of the law.

___ Initial **ITEM 9 – CANCELLATIONS**
Cancellations must be made 24 HOURS before your session. Your session time is reserved for you and you will be charged a **$50.00 no-show fee** for late cancellations or missed appointments. **Our office policy allows three no-show fees before terminating services.**

___ Initial **ITEM 10 – OUTSIDE LAB OR OTHER DIAGNOSTIC TESTS**
We do not get authorization from your insurance for any ordered tests that are performed outside our office. We suggest you contact your insurance carrier to insure that you will be reimbursed for the charges and are aware of your benefit coverage.

___ Initial **ITEM 11 – MANAGED CARE PLANS**
This practice has contracted with several managed care plans and will be handled according to our agreement with them. All co-payments must be paid at time of service. It is your responsibility to be aware of coverage variables, such as preventive health care, deductibles, etc., and to pay for services not covered by your insurance company. Following notification from the insurance company, any denied amounts will be due immediately, upon being notified by our office.

___ Initial **ITEM 12 – ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION**
I hereby authorize my insurance carrier to pay benefits directly to Family Psychiatry of The Woodlands, P.A. for services provided to myself or my insured dependent, realizing I am responsible to pay for all services provided. I hereby authorize the release of pertinent information required by my insurance carrier to process insurance claims for payment to Family Psychiatry of The Woodlands, P.A.

___ Initial **ITEM 13 – PAGING SYSTEM**
There is a 24-hr paging system for emergency situations. There is a $45.00 charge for non-emergent after hour calls.

___ Initial **ITEM 14 – EMERGENCY SERVICES**
I agree to contact ***Family Psychiatry of The Woodlands*** or 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

ITEM 15 – FINANCIAL POLICY

___ Initial I acknowledge that I have read and understand the financial policies of this office.

ITEM 16 – NOTICE OF PRIVACY PRACTICES

___ Initial I acknowledge that I have received a copy of the Notice of Privacy Practices of this office effective April 15th, 2003.

ITEM 17 – BILLING INQUIRY

___ Initial If you have billing questions, we will be pleased to help you. Contact our Billing Company, NextGen, at 888-499-0414.

ITEM 18 – LAWSUITS AND DISPUTES

___ Initial If you are involved in a lawsuit or a dispute we may disclose medical information about you in response to a court order. We may also disclose information about you in response to a subpoena. However, all information will be disclosed via medical records. Provider will not report to court to testify in custody cases to determine parental rights.

Items 1 – 18, initialed by me, indicate my understanding of legal Terms and Conditions in connection with the treatment of patient.

_____ _____ _____

Patient Signature Initials Date

_____ _____ _____

Parent/Guardian Signature Initials Date

Effective 7/16/08; Revised 02/16/2018

FAMILY PSYCHIATRY OF THE WOODLANDS

CREDIT CARD POLICY FOR NO SHOW AND/OR LATE CANCELLLATION APPOINTMENTS

Effective immediately we now require a credit or debit card on file with our office for no show and/or late cancellation (less than 24-hour notice) appointments.

As you may have experienced when you check into a hotel or rent a car, the first thing you are asked for is a credit card which is swiped and later used to pay if you do not cancel your reservation within 24 hours.

Our office requires that a valid credit or debit card is provided at the time of service to be kept on file. In the event of a no show and/or late cancellation, payment of this balance will be charged to the credit/debit card.

If you have any questions about this policy, please do not hesitate to ask.

Frequently Asked Questions:

Why the change? Our office has had an increase in no shows and late cancellations. This causes a loss of revenue for our providers and the practice. These appointment slots could be used for other patients needing an appointment.	I'm nervous about leaving my credit card. We store your credit card information on a secure site and only access your information to process a payment. Only authorized Business Office Personnel have access to this information.
How will I know how much you are going to charge me? The no show/late cancellation fee for an MD, Nurse Practitioner, Physician Assistant and Registered Nurse is $50.00 and for a Psychologist is $65.00	What if I need to dispute my bill? We will always work with you to understand if there has been a mistake and we will refund you if we have made an error.

Signature: _____ Date: _____

Printed Name: _____ Patient Name: _____

FAMILY PSYCHIATRY OF THE WOODLANDS

Family Psychiatry of the Woodlands

Credit Card Authorization Form

I, _____, give authorization to have my Credit Card
(Please Print)

charged and billed for services rendered.

Patient Name: _____
(Please Print)

Card Holder Name: _____
(Please Print)

Card Holder Signature: _____

Please Mark **AND** Initial All that Apply

☐ All Office Visits
Keep Card # On File _____ Card Holder's Initials

☐ Hospital Charges Only _____ Card Holder's Initials

☐ Misc. Fees
Forms, Letters, RX's _____ Card Holder's Initials

***********FOR OFFICE USE ONLY***********

Patient Name: _____ DOB: _____

Encounter #: _____ Provider: _____

Card Type: **VISA** **MASTERCARD** **AMEX** **DISCOVER**

Card Number: _____

Expiration Date: _____ CVV Code: _____

***CVV Code is found on the back of the card. Card must be present to process charge.*

Date of Service: _____

Amount to be charged: _____

Date to be Ran: _____

FPW Office Staff: _____ Date: _____

8701 New Trails Drive, Ste. 150 The Woodlands, Texas 77381 | Tel: 281.367.1015 Fax: 281.367.1966

Family Psychiatry of the Woodlands, P.A.
8701 New Trails Drive, Ste. 150
The Woodlands, Texas 77381
Effective 7/16/08; Revised 07/25/2016

Clients'/Patient's Rights

1. You have all the rights of any other resident of the State of Texas and the United States of America.
2. You have the right to not be discriminated against based on age, race, ethnicity, gender, sexual orientation, religion, national origin, physical or mental disability, or other attributes.
3. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
4. You have the right to be free from abuse, neglect, and exploitation.
5. You have the right to be treated with dignity and respect.
6. You have the right to be told about the treatment you will be given, the risks, side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.
7. You have the right to accept or refuse treatment after receiving this explanation.
8. You have a right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
9. You have the right to know the qualifications of the staff responsible for your treatment.
10. You have the right to refuse to take part in research without affecting your regular care.
11. You have the right not to be given medication you don't need, or too much medication.
12. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
13. Unless otherwise prohibited by law, you have the right to withdraw at any time your permission for something you agreed to earlier.
14. You have the right to make a complaint and receive a fair response from this facility within a reasonable amount of time.
15. You have the right to contact and consult with counsel at your expense.
16. You have the right to select practitioners of your choice at your expense.
17. You have the right to choose whether your parents may be present and participate in your treatment if you are at least 18 years of age.

I acknowledge having read and understood the above client rights.

_____ Date _____
Signature of Patient

_____ _____
Signature of Parent or Legal Representative Date

_____ _____
Signature of Witness Date

Initial Evaluation & Follow-up Medication Visits

Effective 7/16/08; Revised 07/25/2016

Welcome to our practice. Please take a moment to read the following information regarding our office procedures.

On your **First Visit:**

- A clinician will obtain a detailed medical and psychiatric history; this could take 40 - 60 minutes.
- In a few cases, when the diagnosis is not clear from history, we may need additional testing before making treatment recommendations.
- The clinician then explains the diagnosis, treatment recommendations and answers any questions you may have.
- The clinician will also direct you to check out to schedule a follow-up appointment. It is wise to schedule that appointment while in the office, if at all possible.
- The **clinician** who took your history will be your **primary provider contact** while receiving treatment in this office.
- DNA Testing (non-invasive mouth swab) may be performed on you after the completion of your evaluation if you have presented with a history of, history of taking, or your family has a history of, or history of taking the following conditions/medications: Anxiety, Anti-Depressants, Psychosis, ADHD, Analgesic/Pain (Migraine Neuropathic, Arthritis, Musculoskeletal). These tests predict how patients will respond to drug therapy based on their genetic makeup.

For follow-up **Medication Management Visits:**

- Patients routinely are scheduled with the clinician for follow-up medication management visits to assess your treatment response and monitor for side effects. The clinician will meet with you to obtain information regarding your response to the treatment plan.
- For your safety, medication changes are not made over the phone. However, if you feel you are having an adverse reaction, please call your provider immediately.
- You will typically see the clinician for return visits. These visits are scheduled on the half hour throughout the day. For sessions that extend past the 15 minutes, an additional charge will be applied. This will be billed in the form of a 90833 code on your EOB. You will be responsible for any unpaid portions by your insurance carrier.

If you need **Psychotherapy:**

- Psychiatrist, Nurse Practitioners, and Physician Assistants do not see patients for psychotherapy.
- The clinician will refer you to a therapist in our office, if possible, or to a therapist on your insurance plan.

_____ I have read the above policy and understand it.

Initials

Family Psychiatry of the Woodlands, P.A.
8701 New Trails Drive, Ste. 150
The Woodlands, Texas 77381

Effective April 14, 2003;
Reviewed 7/16/08; Revised 07/25/2016

If you have any questions about this notice, please contact HIPAA grievance officer at 281-367-1015. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

➢ WHO WILL FOLLOW THIS NOTICE

Any physician or health care professional authorized to enter information into your chart are all departments of the practice, all employees, staff and other office personnel. In addition, we may share with each other and third party specialists for treatment, payment, and purposes described in this notice.

➢ WE ARE REQUIRED BY LAW TO:

Make sure that medical information that identifies you is kept private. Give you notice of our legal duties. Follow the terms of the notice that is currently in effect.

➢ HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

Treatment- We may use medical information about you to provide you with medical treatment services. We may disclose medical information about you to people outside the office who may be involved in your care. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

Payment- We may use and disclose medical information about you so that treatment and services you receive at our office may be billed to and payment collected from you, and insurance company or a third party.

Appointment Reminders- We may use and disclose medical information to contact you as a reminder that you have an appointment for medical services at the office. We do notify our patients by telephone.

As Required by Law- We will disclose medical information about you when required to do so by federal, state, or local law.

➢ SPECIAL SITUATIONS

Health Oversight Activities- We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes- If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court order. We may also disclose information about you in response to a subpoena. However, all information will be disclosed via medical records. Provider will not report to court to testify in custody cases to determine parental rights.

Coroners, Medical Examiners, and Funeral Directors- We may release medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death.

➢ YOUR RIGHTS: REGARDING MEDICAL INFORMATION ABOUT YOU

Right to Inspect and Copy- If you request a copy of the information, the Provider may deny your request due to mental health liabilities that may cause a patient's to regress if the information is released. Records are released to patients at a fee of $25.00 for the first 25 pages and .25 cents for every subsequent page thereafter.

Right to Amend- If you feel that medical information we have about you is incorrect or incomplete you may ask us to amend the information. In addition you must provide a reason that supports your request. We may deny your request for an amendment but your request will be put into your permanent file as you requested it be changed.

Right to Request Restrictions- You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment, or health care operations.

Right to paper copy of this notice- You have the right to a paper copy of this notice. To obtain a paper copy of this notice please contact us at Family Psychiatry of The Woodlands HIPAA Privacy Officer at 8701 New Trails Drive, #150, The Woodlands, Texas 77381

➢ CHANGES TO THIS NOTICE

We reserve the right to change this notice.

➢ COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with our Grievance Officer at 281-367-1015.

➢ OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice will only be made with your written permission. You may revoke that permission in writing at any time; if you do we will no longer use or disclose medical information. Understand that we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Golfer1

FAMILY PSYCHIATRY OF THE WOODLANDS, PA

Patient & Family History – New Patients

Presenting Problem:
Please state the reason and/or symptoms that brought you here today:

_____

_____

_____

Are there any significant events associated with the above reason? Yes____ No ____
If yes, please provide more information: _____

_____

Check all symptoms you have been experiencing:

( ) recent weight gain How much? _____
( ) recent weight loss How much? _____
( ) difficulty falling asleep (insomnia) ( ) Excessive sleeping ( ) Fatigue
( ) Middle of the night awakening ( ) Decreased energy ( ) Lack of motivation
( ) Restlessness or agitation ( ) Decreased appetite ( ) Increased appetite
( ) Frequent mood swings ( ) Frequent anger ( ) Irritability
( ) Complaints of despair, hopelessness, worthlessness ( ) Inattention
( ) Inability to experience pleasure ( ) Inability to express feelings
( ) Withdrawal from others ( ) Difficulty concentrating
( ) Loss of Libido ( ) Loss of thought process
( ) Difficult focusing resulting in unfinished task

Are you presently having **thoughts of suicide?** Yes____ No____
If yes, please provide more information: _____

_____

_____

Have you ever made a **suicide attempt?** Yes____ No____
If yes, Please provide more information. (When, how) _____

_____

_____

Patient Medical History:

Have you ever had **psychiatric treatment?** Yes____ No____
If yes, please describe: Date: _____ Provider:_____
Reason:_____

_____

History of Substance Use and/or Abuse:
Have you ever used **drugs?** ( ) no ( ) yes

Substance	Age began	Frequency/amount	Last time used
1.			
2.			
3.			

Have you ever been in **treatment** (hospital or outpatient) **for drug** and or **alcohol abuse?** Yes____ No____ If yes, please describe, providing date, provider and type of treatment:

_____

Do you use any **tobacco product**? Yes____ No____
Allergies to medications? _____

_____

History of any of the following conditions? Yes____ (Check below), None _____

- ☐ Meningitis
- ☐ Hepatitis
- ☐ Mononucleosis
- ☐ Renal KIDNEY problems
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood pressure
- ☐ Low Blood pressure
- ☐ Rheumatic fever
- ☐ Seizures (other than febrile)
- ☐ Serious head injury. With or without loss of consciousness? (circle)
- ☐ Other: _____

Surgery: Yes____(Check below), None ____

- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Gallbladder removal (Cholecystectomy)
- ☐ Hysterectomy (partial or complete?)
- ☐ Other: (specify)_____

_____

Current Medical Conditions (diabetes, seasonal allergies, high blood pressure, etc.):

_____

_____

Females: Last menstrual period:_____
Are you currently pregnant? Yes_____ No _____
Breastfeeding? Yes_____ No_____

Developmental history **(Children and adolescents ONLY):**

- Was the pregnancy _____ planned or _____ unplanned?
- Was it full-term? ____Yes ____ No
- Normal pregnancy? Yes _____ No(explain) _____
- How did the mother feel about this pregnancy? _____
- How did the father feel? _____
- Were any alcohols, drugs, or medications used during pregnancy? ____ Yes ____ No
- If yes, please describe:
- Were there any problems with the pregnancy? _____
- Delivery: Normal vaginal ____ C-Section _____
- Was the baby _____ breast fed _____ bottle fed _____ both?
- Who was the primary caretaker for the child? _____

- Estimate when your child first:

Smiled	_____	Sat up on own	_____
Crawled	_____	Stood	_____
Walked	_____	Ran	_____
Said first word	_____	Said phrases	_____
Fed self	_____	Dressed self	_____
Toilet trained	_____		

Current Medications: (Example: Prozac 20mg one a day. Include **all** meds, not just psychiatric ones. Also include any over-the-counter meds, vitamins, etc.)

Medication Name	Dose	How Often	Reason/Treatment of

Family Medical History: check & list – i.e. Mother (M), Father (F), Paternal Grandmother (PGM), etc.

- ☐ Diabetes_____
- ☐ Thyroid disorder_____
- ☐ Heart attack or heart disease_____
- ☐ High blood pressure_____
- ☐ Stroke_____
- ☐ Alzheimer's Disease_____
- ☐ Parkinson's Disease_____
- ☐ Migraine Headaches_____
- ☐ Other (list):_____

Family Psychiatric History: (check & list as above)

- ☐ Depression_____
- ☐ Bipolar Disorder (Manic Depression)_____
- ☐ Schizophrenia_____
- ☐ Alcoholism_____
- ☐ Drug abuse or dependency_____
- ☐ ADHD or ADD_____
- ☐ Obsessive Compulsive Disorder_____
- ☐ Anxiety or Panic symptoms_____
- ☐ Other (list)_____

Religious preference: _____

Are there any cultural issues or religious beliefs that might affect your treatment?

No____Yes (explain) _____

_____

Current Marital Status: Married____, Divorced____, Separated_____, Single____, Widowed____, Number of Marriages____, Non-applicable (child)____

Years in current marriage? _____

Is spouse supportive? Yes____ No (explain_____

_____

_____

_____

Children? Yes____ How many?_____

Child's Name	Age	Biological, step, adopted, foster
1.		
2.		
3.		

Describe who lives in household: (e.g. husband, wife, children, mother, father, siblings pets,etc.)_____

_____

_____

Education: (Check all that apply.)

- ☐ Currently in _____ grade at _____ (name of school) in _____(school district).
- ☐ Dropped out of school in the _____grade.
- ☐ High School graduate Major/Skill learned?_____
- ☐ GED
- ☐ Some college Major/Skill learned?_____
- ☐ 2 year degree (college) Major/Skill learned?_____
- ☐ 4 year degree (college) Major/Skill learned?_____
- ☐ Graduate degree Major/Skill learned?_____
- ☐ Other _____

Work History of Patient: (Current job, how long at job, do you enjoy your work, work stressors?) _____

_____

_____

_____

Family of origin: Grew up in intact family (i.e. Mother & father stayed married.)

- ☐ Parents divorced when patient _____years old. Patient lived with: mother____ father____.
- ☐ History of physical abuse at hands of _____.
- ☐ History of sexual abuse at hands of _____.
- ☐ History of emotional abuse at hands of _____.
- ☐ Siblings: brothers_____ sisters_____ (how many?)
- ☐ Close family relationships.
- ☐ Not very close family relationships.

Completed by: _____ (***Patient or Parent/Guardian***)
(Signature)

Reviewed by: _____

Family Psychiatry of The Woodlands, P.A.
8701 New Trails Drive, Ste. 150
The Woodlands, TX 77381

PRIMARY CARE PHYSICIAN CONTACT FORM

I, *(patient name)*_____, SSN_____, DOB_____, authorize Family Psychiatry of The Woodlands, for the purpose of case consultation/continuity of care, to release & receive information re: my evaluation & treatment to:

Primary Care Physician: _____
Address: _____
Phone # _____ **Fax #** _____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent shall expire on: _____

Patient Signature:_____ Witness Signature_____

Parent or Guardian Signature: _____ Date:_____

**********DO NOT WRITE BELOW THIS POINT**********

This patient is currently under my care for: _____Evaluation only
_____Medication management
_____Detoxification from _____
_____Other_____

This patient has been placed on the following medication(s)/dosage(s): _____
_____
_____
_____

This office has ordered the following labs/tests (circled):

CBC	Depakote level	Lithium level	Serum pregnancy
Chem 20	Desipramine level	Tegretol level	Urine pregnancy
Liver function	Doxepin level	Urinalysis	Urine drug screen
Thyroid profile	Imipramine level EKG	Other: _____	

I have requested that this patient consult you re: _____
_____

I have also referred this patient to: _____
_____

If you have any questions or concerns regarding my treatment of this patient, please feel free to contact my office.

Treating Provider:

_____	**Marshall Lucas, M.D.**
_____	**Cynthia DeVos, M.D.**
_____	**Mark Lejsek, PMHNP-BC**
_____	**Stacey Sullivan, RN, MSN, PMHNP-BC**
_____	**Aveleigh Cook, MSN, RN, PMHNP-BC**
_____	**Brian Graham, MSN, RN, PMHNP-BC**
_____	**Glenn Humphress, PA**
_____	**Eric A. Bell, Psy.D**
_____	**Michael Deitch, Psy.D**
_____	**Michael Graves, MSN,PMHNP-BC**
_____	**Bradley Borsboom, MSN, PMHNP-BC**

Mailed to PCP by _____ Date__/__/_____