Patient Name:_____, _____
Last, First

Rubina Shakil, M.D.
Psychiatric Associates of North Texas, PA
8072 Preston Road, Suite 204,
Frisco, TX 75034

Website : http://www.psychassociatesofnorthtx.com/

Phone: (214) 618-2225
Fax: (214) 618-8045

WELCOME

We realize that you have a choice when it comes to psychiatric care providers. Thank you for choosing Psychiatric Associates of North Texas. We welcome you as a new patient and hope that you are satisfied with the services we provide you. We look forward to seeing you as a returning patient and continuing our partnership with you thereafter.

Please complete the attached forms. These completed forms are necessary for us to meet your needs and provide you the best of care. When you have completed the forms, please return them to the receptionist's counter and have your ID, insurance card, and payment ready. Thank you.

Welcome!

From Dr. Shakil and Staff

Do not fill this document in Google Docs or any other online app

Please print and complete in **BLACK INK** and bring into the office **30 minutes** prior to your appointment time. If you are not able to complete the paperwork prior to coming into the office, we ask that you arrive 45-60 minutes prior to your appointment to complete the new patient process. **Please remember to bring in your driver's license and insurance cards**. Should you need to change or cancel your appointment, please give our office a 72 hours notice as this is a scheduled 45 minutes appointment. **This Intake Form can also be filled online before printing. Please do not print double-sided pages.**

In case you want to electronically send the completed New Patient Paperwork to us, please send the completed form along with a copy of your driver's license and insurance cards to info@psychassociatesofnorthtx.com

Please be advised, our office makes confirmation calls to new patients 48 hrs and 24 hrs prior to their appointment. Should we need to leave a message, it is imperative that you return the calls to confirm your appointment. **If no return calls, we assume you are not coming into the office and therefore, your appointment will be canceled.**

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BASIC INFORMATION

Please Print and Fill Out Completely

Patient Name:_____
Last *First* *MI*

Gender: _____ Date of Birth: _____ Age: _____

Address: _____
Street *City* *State* *Zip Code*

Home #: _____ Cell #:_____Work #:_____

Email: _____ Social Security #: _____

Primary Care Doctor's Name: _____ Office #:_____

Employed: ☐ Yes ☐ No (If No, check the box and skip to the next section)

Name of Employer: _____ Occupation: _____

Address: _____
Street *City* *State* *Zip Code*

Highest Level of Education:_____

Marital Status: *(Please select one)*

☐ *Single (Never Married)* ☐ *Married x ___yr* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

Children (Y/N) :☐ *Number of Boys :* ☐ *Boys Ages :* _____

Number of Girls ☐ *Girls Ages :* _____

Currently live with_____

How did you hear about us? *(Please select one)*

☐ *Friend* ☐ *Relative* ☐ *Health Care Professional* ☐ *Internet* ☐ *Phone Book*

Name of the person who referred you (if applicable): _____

Referring Doctor/Hospital Name: _____ Office #:_____
(Required if you are being referred by another provider)

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WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?

Name: _____ Phone #: _____

Address: _____

Relationship to Patient: _____

Insurance: _____ Policy Holder Name: _____

Group #: _____ Member ID: _____

RESPONSIBLE PARTY

Who is the guarantor? (Who will be responsible for paying?) For example, if the patient is a minor, this might be a parent/guardian. If the claim to be filed on an insurance policy your spouse has through their employer, this would be your spouse's information.

☐ Same as Patient (If you are the patient and will be responsible for the finances, check the box and skip to the next section)

Name:_____
Last *First* *MI*

Social Security # _____ Date of Birth _____

Address: _____
Street *City* *State* *Zip Code*

Home #: _____ Cell #:_____Work #:_____

Occupation: _____Employer:_____

Employer Address: _____
Street *City* *State* *Zip Code*

Patient/Guardian Signature :_____ Date: _____
(By filling in your name, initials or electronic signature on the signature line will have the same legal effect as a handwritten signature)

Name of legal guardian/caretaker (if applicable): _____

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CONTACT AND DISCLOSURE AUTHORIZATION

Print Patient Name: _____ **Date:** _____

Please contact me in the following ways: (check all that apply)

☐ By my **home phone**, my number is: _____

☐ It is ok to leave me a message with detailed information.

☐ It is NOT ok to leave me a message with detailed information.

☐ By my **cell phone**, my number is: _____

☐ It is ok to leave me a message with detailed information.

☐ It is NOT ok to leave me a message with detailed information.

☐ By my **work phone**, my number is: _____

☐ It is ok to leave me a message at work with detailed information.

☐ It is NOT ok to leave me a message at work with detailed information.

☐ It is ok to only leave a call back number at my work number.

I authorize you to discuss my medical history and release any and all medical information to the following people: (complete all that apply)

☐ My spouse, whose name is: _____ Phone _____

☐ My parent, whose name is: _____ Phone _____

☐ No one other than myself

☐ Another person I choose: _____ Phone _____
Last *First*

Patient/Guardian Signature: _____
(By filling in your name, initials or electronic signature on the signature line will have the same legal effect as a handwritten signature)

Name of legal guardian/caretaker (if applicable): _____

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PATIENT HISTORY

Print Patient Name: _____ **Date:** _____

Medication causing Allergic Reaction:

_____ Allergic Reactions : _____

Medical History:

- ☐ HIV
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Sinus Problems
- ☐ Hepatitis Type _____
- ☐ Heart Attack
- ☐ Stroke
- ☐ Palpitations
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Prostate Problems
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Asthma
- ☐ COPD
- ☐ ENT Problems
- ☐ Ulcers
- ☐ Liver Disease
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Thyroid Problems
- ☐ GI Problems
- ☐ Kidney/Bladder Issues
- ☐ Arthritis
- ☐ Chronic Lung Disorder
- ☐ Bronchitis
- ☐ Hard of Hearing
- ☐ Seizures
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Chronic Pain
- ☐ High Cholesterol
- ☐ Anemia
- ☐ Gyn Problems
- ☐ Back/Neck Problems
- ☐ Cancer _____

☐ Other Significant Illness _____

Check all symptoms that apply:

- ☐ Sad/Depressed Mood
- ☐ Panic Attack
- ☐ Poor Sleeping
- ☐ Anger Outbursts
- ☐ Loss of Energy
- ☐ Easily Distracted
- ☐ Sexual Problems
- ☐ Racing Thoughts
- ☐ Dizziness/Fainting
- ☐ Marital or Family Problems
- ☐ Prostate Problems
- ☐ Trouble Eating/Appetite Problems
- ☐ Menstrual Problems
- ☐ Feeling Hopeless
- ☐ Mood Swings
- ☐ Sleeping too much
- ☐ Hearing Voices
- ☐ Poor Attention
- ☐ Confusion
- ☐ Hallucinations
- ☐ Trouble Concentrating
- ☐ Tightness/Chest Pain
- ☐ GI Problems
- ☐ Blurred Vision
- ☐ Constipation
- ☐ Frequent Urge to Urinate
- ☐ Severe Anxiety
- ☐ Paranoia
- ☐ Social Fears or Withdrawal
- ☐ Trouble Remembering
- ☐ Poor Memory
- ☐ Seizures
- ☐ Suspicious Feelings
- ☐ Thoughts about Suicide
- ☐ Ringing in Ears
- ☐ Anemia
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Frequent Headaches/Migraines

☐ Other Significant Symptoms : _____

On average how many hours per night have you been sleeping over the past 2 weeks ? _____

Have you ever been *physically* and/or *sexually* abused ? ☐ No ☐ Yes

Do you smoke cigarettes? ☐ No ☐ Yes How long? _____ Packs per day? _____

If No, previous cigarettes smoker? ☐ No ☐ Yes How long? _____ Packs per day? _____

Do you drink alcohol ? ☐ No ☐ Yes Drinks per week? _____

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Women :

Is there a possibility that you are pregnant ? ☐ No ☐ Yes

Are you considering pregnancy ? ☐ No ☐ Yes Date of Last Menstrual Period _____

Are you taking birth control pills? ☐ No ☐ Yes Are you Nursing? ☐ No ☐ Yes

Have you *ever* experimented with and/or abused any of the following?

☐ Marijuana ☐ Cocaine ☐ LSD ☐ PCP ☐ Methamphetamines (*Ice, Crank, Speed, Crystal Meth, Speed*)
☐ Opiates (*Heroin, Oxycontin, Oxycodone, Percodan, Percocet, Hydrocodone, Lortab, Norco, Vicodin, Morphine*)
☐ Benzodiazepines (*Xanax, Ativan, Valium, Klonopin*) Other: _____

Are you *currently* using any of the following?
☐ Marijuana ☐ Cocaine ☐ LSD ☐ PCP ☐ Methamphetamines (*Ice, Crank, Speed, Crystal Meth, Speed*)
☐ Opiates (*Heroin, Oxycontin, Oxycodone, Percodan, Percocet, Hydrocodone, Lortab, Norco, Vicodin, Morphine*)
☐ Benzodiazepines *not prescribed* for you (*Xanax, Ativan, Valium, Klonopin*) Other: _____

Have any of your relatives been treated for Psychiatric Disorders? ☐ No ☐ Yes

If Yes then,

	Depression	**Schizophrenia**	**Bipolar**	**Anxiety Disorder**	**ADHD**	**Substance Abuse**	**Suicide Attempts OR Suicide Completed**
Mother							
Father							
Brothers							
Sisters							
Sons							
Daughters							
Grand Parents							
Uncle/ Aunts							
Cousins							

Current Medications Name (including non-prescription) Dosage Times per day

_____

_____

_____

_____

_____

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Past Psychiatric Medications:

Name	How long taken	When stopped

Past Hospitalizations for Psychiatric Illness:

Where	Date	Reason

Past Hospitalizations for Other Medical Illness or Surgery:

Where	Date	Reason and Procedure (if applicable)

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PRESENTING PROBLEMS

Print Patient Name: _____ **Date:** _____

Please tell us what problem(s) brought you to our office today?

_____

_____

_____

_____

_____

_____

When did the problem(s) first begin?

_____

_____

_____

_____

_____

What symptoms are you currently experiencing?

_____

_____

_____

_____

_____

Is there anything else you would like us to know?

_____

_____

_____

Rubina Shakil, M.D.
Psychiatric Associates of North Texas,
PA Phone: (214) 618-2225

OFFICE POLICIES

- **Professionalism and Service.** Our office strives to meet the highest standards of quality and professionalism. We seek to provide excellent patient care in a respectful and cooperative environment.
- **Feedback.** Patients are our first priority. We welcome your feedback about your experience here and the service we provide you. Please let us know how we are doing.
- **Confidentiality.** Doctor - Patient confidentiality is the cornerstone of psychiatric treatment. A copy of the Psychiatric Associates of North Texas, P.A., "HIPAA NOTICE OF PRIVACY PRACTICES" stored at https://www.psychassociatesofnorthtx.com/ and should be reviewed and signed. It is often helpful for Dr. Shakil to communicate with other physicians or therapists. She may ask for your permission to communicate with your other physicians or therapists in order to enhance your continuity of care.
- **Client Communications.** For routine matters, please leave a message on the office phone number and Dr. Shakil will return your call as soon as possible, generally within 1 business day. Messages left after 3:00 pm will be returned the next business day.
- **Psychiatric Emergencies.** For emergencies, please call 911 or go to the nearest emergency room.
- **Prescription Refills.** New prescriptions will not be issued without first seeing Dr. Shakil. All prescription refill requests require 2 business days notice. It is the patient's responsibility to monitor the prescription prior to depletion and call the clinic to request a prescription. Prescriptions for a stimulant medication (Schedule II controlled substance) CANNOT be called or faxed into the pharmacy and MUST be filled within 21 days.
- **Form Completion.** All forms requiring medical review and physician signature – including FMLA, disability or other paperwork is subject to an administrative fee. Filling in such forms requires monitoring of psychiatric condition. There are a minimum of **5 office visits** required to properly monitor the psychiatric condition before such forms can be filled in by the clinic. Final determination of disability is solely upon the physician.
- **Appointments.** Office visits are by appointment only. Please arrive at least 15 minutes before your scheduled appointment.
- **Appointments Gap.** Unless advised by the physician, a follow-up appointment gap of more than 6 months would require a new patient appointment.
- **Courtesy.** Please turn off the ringer volume on your cell phone and refrain from leaving children unattended.
- **Termination.** We reserve the right to stop providing services to patients who are non-compliant with treatment, do not pay for services, miss more than three scheduled appointments, or for other reasons we deem reasonable.

I have read, have understood, and do accept and agree to comply with all of the above office policies.

Patient/Guardian Signature: _____ Date: _____
(By filling in your name, initials or electronic signature on the signature line will have the same legal effect as a handwritten signature)

Patient Name: _____

Name of legal guardian/caretaker (if applicable): _____

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Phone: (214) 618-2225

FINANCIAL POLICIES

Thank you for choosing the Psychiatric Associates of North Texas for your medical care. We are committed to providing you with quality personal health care. To reduce confusion or misunderstanding, we ask that you read this policy, ask any questions that you may have, and sign the Authorization and Acknowledgment section of this form. Other than for true medical emergencies, agreement with this policy is required for all medical care.

- **Payment.** Payment must be made at the time we provide services to you. There are no exceptions. We accept the following forms of payment: Cash, Debit Card, Personal Check, American Express, Discover, Master Card and Visa. In case of Insurance, Copay/Deductibles must be made at the time of service. Overdue balance would be calculated after the insurance payment. Payment would become due then.

- **Insurance:** We participate in most of the major healthcare insurance plans and will bill your insurance plan as may be necessary. If we do not participate with your healthcare insurance plan, payment in full is required at the time of service. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your insurance company for questions you may have regarding your coverage. **You are responsible for any services not covered by your insurance plan**.

  - **Proof of Insurance.** All patients must complete and/or update our Patient Information Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to the time of service. Insurance denials for termination of coverage will be automatically billed to you.

  - **Co-payments and deductibles.** All co-payments, deductibles and co-insurance must be paid at the time of service. Protection of your insurance benefits requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductible and non-covered services.

  - **Claim submission.** We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Texas insurance law requires your insurance company to provide timely payment. Please be aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.

  - **Referrals.** If your managed care plan requires prior approval or authorization for referrals to a specialist it is *your* responsibility to arrange for the referral *prior* to your appointment with Dr Shakil. Retroactive referrals cannot be accepted.

- **OTHER SERVICES, CHARGES AND PATIENT RESPONSIBILITIES:** Insurance coverage generally does not include coverage for many administrative services, such as requests for information and form completion. ***The following services may have an administrative service charge that will be billed directly to you and are your responsibility for payment***. Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

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- **Missed appointments.** Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. If you are late for your appointment, we may cancel it to facilitate our clinic operations. If you cannot be at your scheduled appointment, you must contact the office as soon as possible. If you cancel your appointment less than 24 hours in advance, you will be charged $50 which must be paid before your next scheduled appointment.

- **Form completion.** All forms requiring medical review and physician signature – including FMLA, disability or other paperwork is subject to an administrative fee of $35.00. Filling in such forms requires monitoring of psychiatric condition. There are a minimum of **5 office visits** required to properly monitor the psychiatric condition before such forms can be filled in by the clinic. Final determination of disability is solely upon the physician.

- **Requests for Medical Records.** Psychiatric Associates of North Texas requires written requests for the release of medical records in accordance with Texas law. The administrative fee associated with copying medical records is based on current Texas law, which allows up to 15 business days to release the requested copies to you. Please take this into consideration when requesting copies of your medical records. There will be a fee for expedited copies of medical records. There is a $25.00 fee for written correspondence to an employer or school (excluding excuses from work or school due to illness or clinic visits).

- **Care for minors.** A parent or legal guardian must accompany minor patients on their visits. The accompanying adult is responsible for payment of the account, according to the policy outlined above.

- **Delinquent accounts.** Statements will be mailed for outstanding balances. If more than one statement is mailed in an attempt to collect an outstanding debt an administrative fee may be assessed. Delinquent accounts will be submitted to an outside collection agency once the payment due is past 60 days. If your account is transferred out of our office for collection, you will be responsible for all fees incurred by Psychiatric Associates of North Texas to collect your outstanding debt.

- **Returned checks**: Returned checks will incur a fee of $35.00. If more than one returned check is received on your account, we will require all future payments be made by cash, cashier's check or credit card. Any checks that are not paid will be filed with the District Attorney's office for collection. All fees incurred in the filing will be your responsibility.

I have read, have understood, and do accept and agree to comply with all of the above financial policies.

Patient/Guardian Signature: _____ Date: _____
(By filling in your name, initials or electronic signature on the signature line will have the same legal effect as a handwritten signature)

Patient Name: _____

Name of legal guardian/caretaker (if applicable): _____

Rubina Shakil, M.D.
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HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT/GUARDIAN ACKNOWLEDGMENT/CONSENT

I understand that all information shared with the mental health providers at Psychiatric Associates of North Texas, P.A. is confidential and no information will be released to anyone outside of the practice without my consent. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the staff at Psychiatric Associates of North Texas, P.A. is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being abused or is at risk of being abused, the staff at Psychiatric Associates of North Texas, P.A. is legally required to take steps to protect the child or elderly, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the staff at Psychiatric Associates of North Texas, P.A. is bound by law to comply with such requests.

By my signature below, I acknowledge that I have reviewed and understood Psychiatric Associates of North Texas, P.A., "HIPAA NOTICE OF PRIVACY PRACTICES" stored at https:// www.psychassociatesofnorthtx.com/, which explains how my medical information will be used and disclosed. I have been given the opportunity to ask questions about this Notice and my privacy rights.

By my signature below, I also consent to the use or disclosure of my Protected Health Information as described in "HIPAA NOTICE OF PRIVACY PRACTICES".

I understand that I may revoke my consent at any time by giving written notice. I understand that this consent is voluntary and that I may refuse to sign it. I understand that if I do not grant my consent, however, you are legally permitted to refuse to provide health care services to me.

Patient/Guardian Signature: _____ Date: _____

(By filling in your name, initials or electronic signature on the signature line will have the same legal effect as a handwritten signature)

Patient Name: _____

Name of legal guardian/caretaker (if applicable): _____

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CONTROLLED SUBSTANCE POLICIES

Please be advised that it is extremely hazardous to obtain prescription medications for controlled substances from numerous providers. Patients who receive prescription drugs such as controlled substances from pharmacies shall provide our office with prior written authorization to communicate with pharmacies as well as other providers for the purpose of compliance with this various regulations and policies. As a result of affixing your signature to this policy, you moreover concur with the pursuing regulations in an effort to safeguard you in addition to prescribing providers.

- You acknowledge and agree to notify our clinic of any new medications as well as any all medical conditions and/or adverse affects you experience from any of the medications that you consume. You shall utilize the prescribed dosage for the prescribed controlled substance. You will not share, sell, trade, exchange your prescription(s) for revenue, products, services or in any other manner enable other individuals to possess use of this (these) prescription(s). You consent to keep and/or maintain this (these) prescription(s) in a secure and safe location.
- Determination of medication and dosage is solely Dr. Shakil's decision based on her evaluation of your medical condition and determination of medical necessity.
- Refills are exclusively provided as determined by Dr. Shakil; absolutely no premature refills will be provided regardless of the circumstances (i.e., stolen, misplaced, mislaid, exceeding prescribed dosage etcetera).
- Schedule II Controlled Substance prescriptions pertaining to stimulant drugs (Adderall, Ritalin, Concerta, Dexedrine, Dextrostat, Daytrana, etcetera.) cannot be telephoned or faxed to the pharmacies and MUST be filled within 21 days (twenty-one days.) In circumstance where a prescription for any stimulant medication is not filled within 21 days (twenty-one days,) the expired prescription must be returned before a new prescription can be reissued. Please note there shall be a $25.00 (twenty-five dollars) charge to rewrite expired prescriptions.
- Changes and/or alterations in prescriptions shall only be made in the course of clinic visits and never via telephone and / or during non-clinic hours.
- Urine drug screenings may be requested to track your consumption of prescribed controlled substances and to screen for the use of illegal substances. Refusal to consent to such testing shall subject you to a medication taper schedule and may result in the discontinuance of your prescription.
- Altering the date, quantity, and / or strength of medications or altering a prescription by any means, shape, or form is prohibited.

Forging prescriptions and / or Dr. Shakil's physician's signature is prohibited and violates state and federal law. Our clinic fully cooperates with local, state and federal law enforcement agencies as well as the Drug Enforcement Agency (DEA) in regard to infractions involving prescription medications. The patient's pharmacy, local authorities, and DEA will be notified if the treating physician believes the law has been violated in any manner by the patient.

If it is determined that any of the above policies have been violated, all orders for these prescriptions will cease and the patient may be dismissed from the care of this office.

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Psychiatric Associates of North Texas, PA
Phone: (214) 618-2225

Print Patient Name: _____ **Date:** _____

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE POLICY:

I have read and understand the policies regarding controlled substance prescriptions. I agree to the terms involved in the Controlled Substance Policy and have received a copy of this policy. I understand that if any of the above policies are violated or I choose not to adhere to these policies, I will be dismissed from this clinic and will not receive any refills from the treating physician.

Patient/Guardian Signature: _____
(By filling in your name, initials or electronic signature on the signature line will have the same legal effect as a handwritten signature)

Name of legal guardian/caretaker (if applicable): _____

COUNSELING SERVICES AGREEMENT

I understand that while counseling may provide significant benefits, it may also pose risks. Counseling may cause me to experience uncomfortable thoughts and feelings, or may lead me to recollect distressing memories.

I hereby consent to participate in counseling services offered to me by Psychiatric Associates of North Texas, P.A. I understand that I have the right to stop treatment at any time.

Patient/Guardian Signature: _____
(By filling in your name, initials or electronic signature on the signature line will have the same legal effect as a handwritten signature)

Name of legal guardian/caretaker (if applicable): _____

PSYCHIATRIC ASSOCIATES OF NORTH TEXAS, PA
8072 Preston Road, Ste 204, Frisco, Texas 75034
Phone : 214-618-2225
Fax : 214-618-8045

TELEPSYCHIATRY PATIENT CONSENT FORM

Online Fillable Form

Patient Name:_____

In order to receive telepsychiatry services from Psychiatric Associates of North Texas, P.A., you must be a Texas State Resident.

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telepsychiatry are:

- Reduced wait time to receive psychiatric care.
- Avoiding the need to travel to a psychiatrist.

The potential risks of telepsychiatry include, but are not limited to:

- A telepsychiatry session will not be exactly the same, and may not be as complete as a face-to-face service.
- There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session and affect the decision-making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- A lack of access to all the information that might be available in a face to face visit, but not in a telepsychiatry session, may result in errors in judgment.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Psychiatric Associates of North Texas, P.A. utilizes software that meets the recommended standards to protect the privacy and security of the telepsychiatry sessions. However, the service cannot guarantee total protection against hacking or tapping into the telepsychiatry session by outsiders. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry:

- Traditional face-to-face sessions.

I understand that I have the following rights with respect to telepsychiatry:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
- I also understand that the dissemination of any personally identifiable images or information from the telepsychiatry interaction to researchers or other entities shall not occur without my written consent.

PSYCHIATRIC ASSOCIATES OF NORTH TEXAS, PA
8072 Preston Road, Ste 204, Frisco, Texas 75034
214-618-2225

- I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatrist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- In addition, I understand that telepsychiatry based services and care may not be as complete as face-to- face services. I also understand that if my psychiatrist believes I would be better served by another form of psychiatric services (e.g. face-to-face services) I will be referred to a psychiatrist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry, and that despite my efforts and the efforts of my psychiatrist, my condition may not be improve, and in some cases may even get worse.
- I understand that I may benefit from telepsychiatry, but that results cannot be guaranteed or assured.
- I understand that I have a right to access my medical information and copies of medical records in accordance with Texas Law.

Patient's Responsibilities

- I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand I need to make an account with Skype or other online communication providers in order to partake in my appointment. I understand that best connectivity would possibly be over WiFi.
- I understand that my psychiatrist determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.
- I understand that if the telepsychiatry session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow up face-to-face visit, or a second telepsychiatry visit.
- I can change my mind and stop using telepsychiatry at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive health care.
- **I understand that I cannot be driving during the telepsychiatry session.**

Patient Consent to The Use of Telepsychiatry:

I hereby consent to engaging in telepsychiatry with Psychiatric Associates of North Texas, P.A., as part of my psychiatric evaluation and treatment. I understand that "telepsychiatry" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding telepsychiatry.

Name of Patient: _____

Patient Date of Birth: _____

Initials of Patient or Guardian or Representative: (My Initials constitute as signature) : _____
(By filling in your initials on the initials line will have the same legal effect as a handwritten signature)

Date : _____

Name of legal guardian/caretaker (if applicable): _____