PSYCHHEATH VICTOR ZAMORA PMHNP

PATIENT REGISTRATION

All paperwork must be completed and returned prior to appointment scheduled

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle Initial) Preferred Name

Mailing Address: _____

Phone: (H) _____ (C) _____ (W) _____

Social Security#: _____ Sex: □ Male □ Female DOB: _____ Age: _____

Email Address: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other _____

MAY WE CONTACT YOU BY PHONE FOR APPOINTMENT REMINDERS: o **YES** o **NO IF YES PREFERRED#** □ **H** □ **C** □ **W**

A COPY OF THE PSYCHIATRIC EVALUATION WILL BE SENT TO THE **REFERRING PHYSICIAN/THERAPIST UNLESS CHECKED** o **DON'T SEND**

RESPONSIBLE PARTY INFORMATION (Person who is financially responsible for payment)

Name: _____ DOB: _____

Relationship to Patient: _____ SS #: _____

Mailing Address: _____

Phone: (H) _____ (C) _____ (W) _____

INSURANCE INFORMATION ***Please send front and back copies of Insurance cards and ID***

Primary Insurance Company: _____ **Provider** Phone# on back of card _____

Name of Insured: _____ Relationship to Pt.: _____

Insured #: _____ Insured DOB: _____

Insured Mailing Address: _____

Effective Date: _____ Employer: _____

Policy#/ Member ID: _____ Group ID# _____

Secondary Insurance Company: _____ Phone#: _____

Insurance Address: ----------

Name of Insured: _____ Relationship to Pt.: _____

Insured SS#: _____ Insured DOB: _____

Insured Mailing Address: ----------

Effective Date: _____ Employer: _____

Policy#/ Member ID: _____ Group ID# _____

EMERGENCY CONTACT INFORMATION **Different than above*

Name: _____

Relationship: _____ Phone: _____

PATIENT SIGNATURE: _____ DATE: _____

Complete ALL paperwork fully and return at:

Contact@psychhealthtx.com

PSYCHHEALTH **VICTOR ZAMORA PMHNP-BC**

OFFICE POLICIES AND PROCEDURES

- **Office Hours and Appointments:** Our office hours are Monday through Thursday 8 a.m. to 12 p.m., and 1 p.m. to 5 p.m., and Friday 8 a.m. to 12:30 p.m. Patients can schedule appointments by calling during regular office hours. If you cancel an appointment we require a 24 hours' notice. **You will be charged a $75.00 fee for new patient or a $50.00 fee for established appointments missed or canceled without a 24 hour notice and is payable prior to any future appointments.** These will not be billed to your insurance company and will be your responsibility. **A credit card is required to be kept on file and will be *AUTOMATICALLY* charged for these missed appointments.** Multiple missed appointment. (3 missed) may result in termination from our practice. Late arrivals may not be seen and may be asked to reschedule their appointment. Please be considerate to other patients' appointments and the physician's schedule. **You must present a valid Government issued photo identification and your insurance card prior to being seen at *each appointment.***
- **Termination:** Threats or acts of physical harm to any employee of the practice or office property will result in immediate termination of treatment and notification of the proper authorities.
- **General:** At PsychHealth *we do not practice Forensic Psychiatry. We do not involve in worker's compensation cases, divorce/ child custody cases, disability evaluations or other legal matters including testimony or reports in civil matters.* If you need such services you will need to be referred to another psychiatrist outside of our practice.
- **Phone calls and Emergencies:** We will take phone calls and messages during regular working hours. We will respond to your call no later than the end of the next business day. If you leave a message after-hours we will respond to it the next business day. If you are having an emergency need and cannot wait for a return phone call, or you are in danger of harming yourself or others, please call 911 and go to the nearest Hospital Emergency Room. Please note that we are not a 24-hour facility.
- **Prescriptions and Refills:** We require a ***48-hour notice for prescription refills.*** You are responsible to ensure that you do not run out of your medications. Call your pharmacy to request prescription refills from our office. If you cancel or miss your appointment and require a prescription refill prior to your next scheduled appointment we will only issue a 2-week supply or enough medication to last you till your next appointment whichever is less. Please do not lose your prescription as you will be charged a $15 fees for lost/stolen prescription renewal. **Controlled or scheduled medications may not be replaced or filled early. *All Prior Authorizations will be charged $25.***
- **Financial Policy:** Payment is due at the time of service. We accept cash, check, debit or credit card (Visa, MasterCard, Discover, and American Express). Patients are responsible for their co-payments, deductibles and any outstanding charges at the time of service. Any balance on an account that is greater than 30 days is considered past due. ***Balance of services that are delayed or denied by your insurance company will become your responsibility after 30 days.*** We do not guarantee that payment will be authorized for services and are not responsible to for any adverse payment decisions by your insurance company. **Please provide notification of any changes in your insurance coverage 48 hours in advance of your appointment or payment in full will be required.** We will collect delinquent accounts through a collection agency. In the event of account placement with a collection agency the applicable collection fees will be added to that account.
- **APN/PA consent:** PsychHealth would like you to know that we employ Advanced Practice Nurses, also known as Nurse Practitioners, and Physician Assistants to assist us in a team approach to deliver our high quality of medical care. If you are seen by an APN/ NP or PA, your doctor will review your care with the APN/NP or PA as part of the care plan. / *have read the above and understand that in this practice a team approach is used, with my unique needs presented and discussed with one or more physicians in the development of my care plan.* I also understand that typically one physician will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including a APN/NP or PA. I hereby consent to the services of an Advanced Practice Nurse/Nurse Practitioner or Physician Assistant for my healthcare needs.
- **Miscellaneous Charges:**
    1. **Fees for copies of medical records are $25.00 for the first 20 pages and $0.50 for each page thereafter. It may take up to 15 business days to prepare medical records.**
    2. **Any letter or forms (e.g. FMLA, Prior Auths, etc.) requested by the patient will be charged a preparation fee of $25.00.**
    3. **Returned checks are subject to a $35.00 service fees.**

I acknowledge that I have carefully read and understand the Office Policies and Procedures and accept all the terms as described above. I understand that Office Policies and Procedures may be amended or modified from time to time by the practice.

_____ _____

Patient Name (Please Print) Date

_____ _____

Signature of Patient/Parent/Guardian Relationship to Patient

_____ _____

Witness Date

ACKNOWLEDGEMENTS AND CONSENT

___ I voluntarily consent to receive treatment at PsychHealth. I consent to administration and performance of treatment/diagnostic procedures/ laboratory tests as deemed medically necessary or advisable by my treating physician or their assigned designees.

___ I understand and agree that I will participate in my treatment plan and my non-adherence to treatment recommendations may result in being terminated as a patient. I also understand that I may discontinue treatment or withdraw my consent to treatment at any time.

___ I hereby acknowledge that I have received or been provided the opportunity to receive a copy of the HIPAA privacy practices and understand that any questions or complaints may be addressed to the Privacy Officer without penalty.

___ I authorize my insurance plans to pay directly to Psychhealth the amount due for services rendered to me or the patient covered under the insurance plan. I hereby assign, transfer and set over to Psychhealth all of my rights, title and interest to my medical reimbursement benefits under my insurance plans.

___ I consent to the release of any medical, mental health, or substance abuse information about the patient required by my insurance company, administrator, managed care company, or review agencies, their employees or agents for the purpose of processing insurance claims for services rendered.

___ I agree to take full responsibility for the entire amount due for any and all services rendered that are not covered by my insurance carrier. I also acknowledge that I am personally responsible for any deductibles, copays, or any other balance not covered by my insurance carrier. I fully understand that I may not be able to schedule further appointments if my account becomes delinquent or my account is turned over to collections.

Patient Name:_____

Patient Signature: _____Date: _____

(Guardian's signature if patient is under 18)

Witness: _____Date: _____

CHILD AND ADOLESCENT CONSENT (IF APPLICABLE)

I certify that I am the□ parent,□ legal guardian and have legal custody of the above named patient. I hereby consent and give authorization to Psychhealth for the patient to receive treatment. I will be solely responsible for the payment of the patient's treatment and services rendered at Psychhealth Group. Psychhealth assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements or agreements of any form for the patient's medical care.

Parent/Guardian:_____

Parent/Guardian Signature: _____Date: _____

Witness: _____Date: _____

REVIEW ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICIES AND PRACTICES

I have reviewed PsychHeahth's of Privacy Practices, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient/Guardian:_____

Patient/Guardian Signature: _____Date: _____

Witness: _____Date: _____

Psych Health

VICTOR ZAMORA PMHNP-BC

TELEHEALTH POLICY

Due to the ending of the COVID pandemic emergency per insurance the waivers that have allowed telehealth overall will be ending soon. Some polices will continue to cover this service; however, it is the **patient's responsibility** to know what services are covered under your insurance policy. We will try to verify your benefits to the best of our ability, but we do often receive inaccurate information from health plans regarding benefits. We will continue to provide telehealth services but that **DOES NOT** mean your insurance will pay for the service. By signing this document, you are acknowledging understanding and agree that:

1. Even though you are told by your insurance company that telehealth is covered your insurance could deny the telehealth service and you will be charged the full amount per visit of **$152.00.**
2. Any denied charge for telehealth visits as not a covered service is your responsibility to contact your insurance company for dispute and will not be disputed by our office or rebilled as an in office visit so that it is covered.
3. Any telehealth visit that is denied as not a covered service will result in an immediate charge to your credit card on file for the balance due up to $152.00. Previous co-pay or coinsurance payments made for that date of service will be deducted from total of $152.00 prior to running payment.

*** Please Note: ***We are not associated with and are not providers for Teladoc, Healthiest You, or any other telehealth platform. Those services are only covered if you log into their portals and see their physicians via those portals. Please do not confuse that benefit with being able to see your personal physicians via telehealth as they will be denied.***

PATIENT NAME:_____ DATE OF BIRTH_____

NAME: _____ RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

(Ink signature only- digital signature not accepted to complete request) (Must be dated to complete request)

PSYCHHEALTH

Controlled Substance Policy **Must be signed and received prior to first appointment

I, (name) _____ (DOB)_____ understand that my provider is prescribing a controlled substance medication as part of my treatment plan. This controlled substance policy is a tool for communication allowing us to work together in good faith. This requires cooperation, trust and mutual respect. If you cannot agree with the following terms, we will be unable to prescribe controlled medication.

I. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my physician. I agree to not share my medication with anyone. Initial _____

2. 1 will keep regularly scheduled appointments with my physician. lf refills are needed between office visits, please call our staff at least§. days before your medication runs out. Initial: _____

3. I understand that **NO** early refills of medication will be authorized. Initial: _____

4. I understand that I will **not** be given a dosage that is higher than FDA guideline maximum recommended dosage. I understand if I am currently on a higher dosage than the FDA maximum recommended dosage, then my provider may decide to reduce the dosage or change the medication. Initial: _____

5. I will not accept or seek controlled substance medication from any other physician or health care provider outside of our practice while we are prescribing controlled medication. I understand that I must keep my provider informed of all medication that is prescribed to me outside of this practice. Initial: _____

6. I understand that office staff is not permitted to refill controlled medications without provider approval. Initial: _____

7. I understand that my controlled prescription will only be sent to **one** pharmacy and cannot be transferred or sent to multiple locations. Initial: _____

8. I understand that lost, stolen or misplace prescriptions or pills will **not** be replaced. Initial _____

9. I agree that I will not use any illegal drug(s) while receiving care and medication from this practice. Initial:_____

I 0. I agree and understand that my physician reserves the right to obtain urine drug testing. The drug testing will be required at a minimum of the onset of the prescription and every 3-6 months. Initial prescriptions will not be sent to the pharmacy until drug screen is received. If l fail to obtain drug screen when asked or if the results are inconsistent, I may forfeit the right to continue receiving controlled medication. Initial: _____

11. I understand that I should not mix benzodiazepine (anti-anxiety) medications with alcohol and/or opiate (pain) medications. There is a major risk of decrease respiratory rate that can lead to death when mixing these medications with other substances. Initial: _____

IF YOU HAVE ANY QUESTIONS CONCERNING OUR MEDICATION AGREEMENT OR IF WE CAN ASSIST YOU IN ANY WAY, PLEASE FEEL FREE TO CALL ON OUR OFFICE STAFF.

I have read this agreement. I fully understand the consequences or violating this agreement may include cessation of therapy with controlled substances and/or discharge from this practice.

Print Name:_____ DOB: _____

Signature: _____DATE:_____

3508 McNiel Ave STE D, Wichita Falls, TX 76308 **PH: 940-337-3662**
Fax:214-279-3662

Psych Health

Controlled Substance Policy (Minor) **MUST be signed and received prior to appointment

!,_____ understand that my ***minor child*** _____
(DOB) _____, is being prescribed a controlled substance medication as part of their treatment plan. This controlled substance policy is a tool for communication allowing us to work together in good faith. This requires cooperation, trust and mutual respect. If you cannot agree with the following terms, we will be unable to prescribe controlled medication.

I. I agree that I will keep the medication secure and my minor child will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of their physician. I agree to not share their medication with anyone. Initial ____

2. I agree to keep their regularly scheduled appointments with their provider. If refills are needed between office visits, please call our staff at least 5 days before your medication runs out. Initial: ____

3. I understand that **NO** early refills of medication will be authorized. Initial: ____

4. I understand that they will **not** be given a dosage that is higher than FDA guideline maximum recommended dosage. I understand if they are currently on a higher dosage than the FDA maximum recommended dosage, then their provider may decide to reduce the dosage or change the medication. Initial: ____

5. I will not accept or seek controlled substance medication from any other physician or health care provider outside of our practice while we are prescribing controlled medication. I understand that I must keep their provider informed of all medication that is prescribed to them outside of this practice. Initial: _____

6. I understand that office staff is not permitted to refill controlled medications without provider approval. Initial:____

7. I understand that their controlled prescription will only be sent to the pharmacy and cannot be transferred or sent to multiple locations. Initial: _____

8. I understand that lost, stolen or misplaced prescriptions or pills will **not** be replaced. Initial _____

9. I agree and understand that my physician reserves the right to obtain urine drug testing. The drug testing will be required at a minimum of the onset of the prescription and every 3-6 months. Initial prescriptions will not be sent to the pharmacy until drug screen is received. If I fail to obtain drug screen when asked or if the results are inconsistent, I may forfeit the right to continue receiving controlled medication. Initial: _____

I0. I understand that I should not mix benzodiazepine (anti-anxiety) medications with alcohol and/or opiate (pain) medications. There is a major risk of decrease respiratory rate that can lead to death when mixing these medications with other substances. Initial: ____

IF YOU HA VE ANY QUESTIONS CONCERNING OUR MEDICATION AGREEMENT OR WE CAN ASSIST YOU IN ANY WAY, PLEASE FEEL FREE TO CALL ON OUR OFFICE STAFF.

I have read this agreement. I fully understand the consequences or violating this agreement may include cessation of therapy with controlled substances and/or discharge from this practice.

Print Name:_____ DOB: _____ __

Signature: _____ DATE:_____ __

3508 McNiel Ave Ste D, Wichita Falls, TX 76308 PH: 940-337-3662
Fax: 214-279-7971

Controlled C2 Medication Refill and Prior Authorization policy

Effective 10/01/2023

Prior Authorization of Medication

_____There is a $25.00 charge for each prior authorization that our office is required to obtain. This fee must be paid **before** the prior authorization is processed, for ALL medications that are not listed on the formulary list for your insurance company. **Our office will help you through this process but please understand we cannot guarantee your insurance company will cover medications not on your insurance policy and the fee is non-refundable for denied prior authorizations.**

We advise each patient to obtain a copy of your formulary list prior to your visit, as we have no access to your pharmacy benefit for your insurance plan. This will ensure that the medications being prescribed are covered by your insurance company, and to give you the opportunity to discuss alternatives if possible. Prior Authorizations can take multiple days to process, since they are extremely time consuming. Once the information is submitted it can take your insurance company 10-14 days to respond with a decision. If the prior authorization is denied and we are required to do an appeal it can take 30-60 days after that for your insurance to decide.

Patient Name (Please Print) Date

Signature of Patient/Parent/Guardian Relationship to Patient

Witness Date

Psych Health

VICTOR ZAMORA PMHNP-BC

Consent to Treatment with Psychotropic Medication

Must be signed prior to first appointment

_____, hereby consent to the following:

NAME (PLEASE PRINT)

- The nature of my mental condition, diagnosis and the reason for prescribing medication will be explained to me in detail in terms I understand.
- The risks, benefits and side effects from the medication will be explained to me including the potential consequences of not taking the medication. I will be informed of warnings and precautions about this medication.
- Alternative treatments (including no treatment), and their benefits, risks and advantages/disadvantages will be explained to me.
- I will be informed of the proposed course of treatment with this medication.
- I understand and accept that side effects of varying degrees of severity can occur with any medication including side effects that are frequently occurring in most individuals, side effects to which I may be predisposed, and also potentially dangerous and irreversible side effects. I also understand and accept that additional possible side effects may occur when psychotropic medications are taken for extended periods and may be potentially irreversible and may appear after the medication is discontinued.
- I will inform my treatment provider of all my known allergies.
- I will inform my treatment provider of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements and any other recreational drug or alcohol use.
- I will be advised not to drink alcohol or use illicit drugs and the potential interactions with my medication will be explained to me.
- I am aware and accept that no guarantees about the results of the treatment will be made.
- I understand that any medication can impair thinking or reaction time. I agree not to drive or operate machinery until I am certain that my newly prescribed medication does not affect my abilities.
- If I intend to or become pregnant I agree to notify my treatment provider immediately. I understand that medications can have a harmful effect on the unborn child and may lead to birth defects. However, abrupt discontinuation of medications can have dangerous consequences and I agree to collaborate with my treatment provider in this situation.

If patient or someone else takes more than the prescribed/recommended dose of a medicine, call 911, contact poison control or go to an emergency room immediately.

NAME OF MEDICATIONS:_____

_____

My signature below hereby indicates consent to treatment and understanding of the explanation with the specific medication(s) listed.

_____ _____

PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE

Psych Health

VICTOR ZAMORA PMHNP-BC

PHARMACY INFORMATION

PLEASE PROVIDE THE FOLLOWING INFORMATION FORE-PRESCRIBING TO YOUR PREFERRED PHARMACY

PATIENT NAME: _____

PREFERRED PHARMACY NAME: _____

PHARMACY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHARMACY PHONE NUMBER: _____

PHARMACY FAX NUMBER: .....

Psychhealth is now participating in the ePrescribe program which allows us to electronically prescribe you medication and controlled substances. It allows us to check your formulary and benefits fill status and medication history transaction.

Understanding all of the above, I hereby provide informed consent to Psychhealth to enroll me in this ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature of Patient or Guardian: _____

Date: _____

PsychHealth

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____ **DOB:** _____

I hereby authorize disclosure of my medical information to/from the named individual or organization listed below. Please fully complete the form. **Incomplete forms will be null and void.**

□ ALL HEALTH INFORMATION
□ BILLING INFORMATION
□ OBTAIN MEDICAL RECORDS
□ OTHER _____

Purpose for disclosure: _____

1._____
FULL NAME TELEPHONE NUMBER

_____
ADDRESS

2._____
FULL NAME TELEPHONE NUMBER

_____
ADDRESS

3._____
FULL NAME TELEPHONE NUMBER

_____
ADDRESS

- I understand that specific information to be disclosed may include Drug, Alcohol Abuse or Mental Health Treatment, information regarding communicable diseases including Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency syndrome (AIDS), and other medical conditions, laboratory results, treatment and any other such related information.
- I understand that the information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.
- I authorize that a photocopy of this authorization is acceptable as an original.
- This authorization will remain in effect indefinitely unless revoked in writing. I understand that my treatment is not conditioned upon my providing this authorization. I understand that I have the right to revoke this authorization at any time by providing a written notification to: The Privacy Officer, PsychHealth 3508 McNiel Ave Ste D, Wichita Falls, TX 76308. PsychHealth shall not be deemed responsible for release of any information pursuant to this authorization prior to revocation.
- I understand that there will be a charge for release of photocopies of my medical record. Please indicate below if you need the photocopies of your medical record to be sent to the above named individual or organization.

NAME: _____ RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

PLEASE SEND COPIES OF MY MEDICAL RECORD TO THE ABOVE NAMED INDIVIDUAL OR ORGANIZATION.

□ Entire Medical Record
□ Psychiatric Evaluation
□ Other (Please Specify) _____

A charge of $25.00 for the first 20 pages and $0.50 per additional page applies for copying.