

**ILacone Psychiatry Group Inc.** 301 South 9<sup>th</sup> Street, #118 Richmond Texas 77469

#### REGISTRATION PACKET

Please complete this packet and bring 20 minutes prior to vour first visit with ILacone Psychiatry Group Inc.

All policies, procedures, and listings that are addressed in the registration packet are available on our Website under "Clinic Policies" for you to review and print for your records prior to signing/acknowledging any of the forms in this packet. These policies are also available to you at any time at your request.

Please contact our office at 832-451-6508 if you have any questions.

If the patient is a minor child and the parents are divorced and/or legally separated, please ensure that you bring a copy of the court order(s)/divorce decree. If the court order is not submitted to Desert Horizon prior to your visit, you will be unable to keep your appointment.

Thank you for choosing ILacone Psychiatric Services.



#### Acknowledgment of Receipt

At the time of admission, I have been provided with the following information:

- 1. A list of client rights (MH-211);
- 2. A copy of the Refund Policy and Procedure;
- 3. A copy of the Billing Policy and Procedure that includes;
- a. Notice of fees: Disability paperwork including FMLA or any other leave paperwork will be charged \$ 60 for every 20 minutes scheduled.
- b. Notice of fees: Applicable telephone charges will apply and will be patient responsibility if insurance carrier does not pay.
  - c. Patient responsibilities pertaining to their insurance coverage and outstanding charges.
- 4. A copy of the No Show/Cancellation Policy and Procedure that applies to no shows and/or late cancellations (less than 24 hours-notice):
  - a. NS fee of \$ 60 will apply for med management (M.D.) appointments;
  - b. NS fee of \$ 100 per hour for testing;
  - c. NS fee of \$ 120 for therapy appointments.
- 5. A copy of the Termination Policy and Procedure including, but not limited to:
  - a. Multiple cancellations and/or no shows;
  - b. Non-payment;
  - c. Refusal to comply with recommended treatment;
  - d. Services are beyond the scope of services of the outpatient clinic; and
  - e. Inappropriate behavior.
- 6. The current telephone number and addresses of:
  - a. The OBHL;
  - b. The Department's Division of Behavioral Health Services;
  - c. The human rights advocates provided by the Department of the Department's designee (if applicable);
  - d. The Texas Department of Economic Security Office of Adult Protective Services (if applicable);
  - e. The Texas Department of Economic Security Office of Child Protective Services (if applicable); and
  - f. The local office of the Regional Behavioral Health Authority.
- 7. A copy of the Grievance Policy and Procedure; and
- 8. A copy of HIPAA Notice of Privacy Practices.

I acknowledge receipt of all documents listed above by my signature set forth below. I understand that it is my responsibility to read all policies and procedures provided to me.

Signature of Patient/Parent/Legal Guardian  Dat	e
Print Name	



## Community Contact Information

Texas Department of Family and Protective Services Region 6 Headquarters 2525 Murworth Drive Houston, TX 77054 1-800-252-5400

Call our Abuse Hotline toll-free 24 hours a day, 7 days a week, nationwide.

Texas Department of Aging and Disability Services (DADS) Nursing homes, assisted living facilities, private ICF/MR, adult day care Complaints (reports of abuse): 1-800-458-9858

> Texas Council on Family Violence Domestic Violence Hotline: 1-800-799-7233 (1-800-799-SAFE) 1-800-787-3224 (TDD)

> > MHMRA of Harris County 7011 Southwest Freeway Houston, Texas 77074

Help is Available 24 Hours a Day 7 Days a Week. The MHMRA Help Line is the first contact and representation of MHMRA by phone to the public, consumers and providers. We answer all calls coming into MHMRA of Harris County's main phone numbers as well as 6

MHMR centers and the National Suicide Prevention Life Line 24 hours a day/365 days a year.

713-970-7000

Oakbend Medical Center Psychiatric Unit 1705 Jackson St Richmond, TX 77469-3246

Phone: (281) 341-3000 Fax: (281) 341-4849

301 SOUTH 9TH STREET, SUITE 118 RICHMOND, TEXAS 77469 OFFICE: (832)451-6508 FAX: (832)471-6972



ROGER JOE MD, MBA

# HIPAA Notice of Privacy Practices (Patient Copy)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability Accountability Act of 1996 (HIPAA).

#### Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

#### Use and disclosure of your health information in certain special circumstances:

The following circumstances may require for us to use or disclose your health information:

- 1. To public health authorities and health oversight agencies that are authorized by law to collect information.
- 2. Lawsuits and similar proceedings in response to a court or administrative order;
- 3. If required to do so by a law enforcement official;
- 4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat;
- 5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities:
- 6. To federal officials for intelligence and national security activities authorized by law;
- 7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official:
- 8. For Worker's Compensation and similar programs.

#### Your rights regarding your health information:

- I. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- 2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operation. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
- 3. You have the right to review and copy your protected health information;
- 4. You have the right to have your provider to amend your protected health information. In certain case, we may deny your request for amendment. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- 5. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

6.	You have	the	right to	obtain	a	paper	copy	of	this	N	otice	from	US.
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Signature of Patient/Parent/Legal Guardian	Date	
Print Name		

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# Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use and disclosure of	's Protected Health Information by IPG
	obtaining payment for health care bills or to conduct health care or treatment by IPG may be conditioned upon the consent as ment.
carry out treatment, payment or healthcare operation that I may request. However, If IPG agrees to a rest	as to how protected health information is used or disclosed to one of the practice of IPG is not required to agree to the restrictions triction that I request, the restriction is binding on IPG. I have the except to the extent that IPG has taken action in reliance on this
from me and created or received by his/her physicia health care clearinghouse. This protected health inf	ormation, including his/her demographic information, collected an, another health care provider, a health plan, my employer or a formation relates to past, present or future physical or mental ere is a reasonable basis to believe the information may
Notice of Privacy Practices has been provided to m disclosures of protected health information that will	f Privacy Practices prior to signing this document. IPG's e. The Notice of Privacy Practices describes the types of uses and occur in treatment, payment of bills, or in the performance of y Practices also describes client rights and IPG's duties with
	ces that are described in the Notice of Privacy Practices. I may ng the office and requesting a revised copy be sent in the mail or
Signature of Patient/Parent/Legal Guardian	Date
Print Name	



# Client Rights R9-20-203, 1/3

#### A. A licensee shall ensure that:

- 1. At the time of admission, a client and, if applicable, the client's parent, guardian, custodian, designated representative, or agent receive a written list and verbal explanation of:
- a. The client rights listed in subsection (B) and (C); and
- b. If the client is an individual who is enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, the rights contained in 9 A.A,C, 21;
- 2. A client or, if applicable, the client's parent, guardian, custodian, or agent acknowledges, in writing, receipt of the written list and verbal explanation required in subsection (A)(1); and
- 3. A client who does not speak English or who has a physical or other disability is assisted in becoming aware of client rights.
- B. A licensee shall ensure that a client is afforded the rights listed in A,R.S. §§ 36-504 through 36-514.
- C. A client has the following rights:
  - 1. To be treated with dignity, respect, and consideration;
  - 2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;

To receive treatment that:

- a. Supports and respects the client's individuality, choices, strengths, and abilities;
- b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
- c. Is provided in the least restrictive environment that meets the client's treatment needs;
- 3. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
- 4. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;
- 5. To have grievances considered by a licensee in a fair, timely, and impartial manner;
- 6. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
- 7. To receive assistance from a family member's, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
- 8. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the 9. Department's designee in understanding, protecting, or exercising the client's rights;
- 9. To have the client's information and records kept confidential and released only as permitted under R9-20~2I I(A)(3) and (B);
- 10. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
- a. For photographing for identification and administrative purposes, as provided by A.R.S, § 36-507(2);
- b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
- c. For video recordings used for security purposes that are maintained only on a temporary basis; or
- d. As provided in R9-20-602(A)(5);
- 11. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-21 I(A)(6);
- 12. To review the following at the agency or at the Department:
- a. This Chapter;
- b. The report of the most recent inspection of the premises conducted by the Department;
- c. A plan of correction in effect as required by the Department;

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## Client Rights R9-20-203, 2/3

- d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and
- e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;
- 13. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;
- 14. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;
- 15. To be offered or referred for the treatment specified in the client's treatment plan;
- 16. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
- 17. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S, § 36-512;
- 18. To be free from:
- a. Abuse:
- b. Neglect;
- c. Exploitation;
- d. Coercion;
- e. Manipulation;
- f. Retaliation for submitting a complaint to the Department or another entity;
- g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
- h. Treatment that involves the denial of:
- i, Food,
- i. The opportunity to sleep, or
- k. The opportunity to use the toilet; and
- I. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
- 19. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
- 20. To control the client's own finances except as provided by A.R.S. § 36-507(5);
- 21. To participate or refuse to participate in religious activities;
- 22. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;
- 23. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;
- 24. To participate or refuse to participate in research or experimental treatment;

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## Client Rights R9-20-203, 3/3

- 25. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;
- 26. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
- 27. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility; and if receiving treatment in a residential agency, an inpatient treatment program, a Level 4 transitional agencies or a domestic violence shelter:
- a. If assigned to share a bedroom, to be assigned according to R9-20-405(F) and, if applicable, R9-20-404(A)(4)(a);
- b. To associate with individuals of the client's choice, receive visitors, and make telephone calls during the hours established by the licensee and conspicuously posted in the facility, unless:
- i, The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
- ii. The client is informed of the reason why this right is being restricted; and
- iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
- iv. To privacy in correspondence, communication, visitation, financial affairs, and personal hygiene, unless:
- v. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
- vi. The client is informed of the reason Why this right is being restricted; and
- vii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
- viii. To send and receive uncensored and unopened mail, unless restricted by court order or unless:
- ix. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
- x. The client is informed of the reason Why this right is being restricted; and
- xi. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
- c. To maintain, display, and use personal belongings, including clothing, unless restricted by court order or according to A.R.S,  $\S$  36-507(5) and as documented in the client record;
- d. To be provided storage space, capable of being locked, on the premises while the client receives treatment;
- e. To be provided meals to meet the client's nutritional needs, with consideration for client preferences;
- f. To be assisted in obtaining clean, seasonably appropriate clothing that is in good repair and selected and owned by the client;
- g. To be provided access to medical services, including family planning, to maintain the client's health, safety, or welfare;
- h. To have opportunities for social contact and daily social, recreational, or rehabilitative activities;
- i. To be informed of the requirements necessary for the client's discharge or transfer to a less restrictive physical environment; and I, To receive, at the time of discharge or transfer, recommendations for treatment after the client is discharged.

Signature of Patient/Parent/Legal Guardian	Date	
Print Name		



ROGER JOE MD, MBA

#### PATIENT RECORD OF DISCLOSURES

In general the HIPAA privacy rule gives individuals the right to quest a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI, be made by alterative means, such as sending correspondence to the individual's office instead of the individual's home.



# Patient Identification Form and Financial Responsibility Acknowledgment

Patient Name (Last	, First, Middle):	
Date of Birth:		
(Check One): [ ] M	ale [ ] Female	
Street Address Apt	# (if applicable)	
0.1	Ctata	7:
City	State	Zip
Phone: Parent/ Leg	al Guardian (if applica	ole):
Street Address Apt	#	
City	State	Zip
In case of a medica	l emergency or any o	ner emergency, please list two emergency contacts below:
Name:		Telephone Number:
Name:		Telephone Number:
FINANCIAL RESPO I acknowledge full f is due at the time of to pay all reasonabe authorize and reque I understand that IF understand that it is will assist me in this services rendered. due prior to service insurance. I understand that m IPG. If there are an I have read and full	DNSIBILITY ACKNOV inancial responsibility f service unless other le attorney fees and clest that insurance payor of verifies my mental s my responsibility to estain the best of a process to the best of understand that any s being rendered. I unay health insurance is y disputes of benefit of y understand the about	definite financial arrangements have been made prior to treatment. I agree definite financial arrangements have been made prior to treatment. I agree definite financial arrangements have been made prior to treatment. I agree definite financial arrangements have been made prior to treatment. I agree definite financial arrangements have been to find the prior to treceive such payment. I dealth benefits through my insurance as a courtesy to me. I further insure services are covered and/or what my exact benefits are, not IPG. IPG fits ability. I understand that I am ultimately responsible for payment of all co-pays, deductibles, or any other payments of outstanding balances are derstand that it is my responsibility to update IPG of any changes in a contract between me and the insurance company and/or my employer, not overage, I understand that I need to contact my insurance carrier. The provence of the financial responsibility and insurance authorization.
Signature of Patien	t/Parent/Legal Guardi	n Date
Print Name		

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#### Coordination of Care Form and Release of Confidential Information

SECTION 1 — CLIEN (Release to) Name and	TINFORMATION	Phone	Fax
Address			
City	State	Zip	
SECTION 2 — PATIE (Requestor) Patient Na		DOB:	
Date of Evaluation:			
SECTION 3 — Clinica	I Information (To be com	pleted by treating provider at IP	G)
Reason for referral or	coordination of care:		
Diagnoses:			
Medications currently	prescribed:		
Treatment plan(s) or re	ecommendations:		
Other pertinent inform	ation:		
Medical follow-up reco	ommended:		
BH Provider:		Date I	Faxed:
my medical records to in- records cannot be disclo- revoke this authorization receiving treatment at IP- upon the termination of to answered. I understand to can change my mind at a authorize IPG and the pr	clude information related to sed without my written cons at any time, except to the e G, I understand that this correatment, unless I express what I do not have to allow reany time and revoke my autiovider noted on this consen	all diagnosis and substance use. I usent unless otherwise provided for in extent that action has already been to a sent will automatically expire one (for written revocation at an earlier date, belease of my medical and/or HIV and horization by writing to the facility and	verbal, written and/or by providing copies of inderstand and have been explained that me the regulations. I understand that I may aken to comply with it. If I am currently 1) year after the revocation of this release of Any questions about this form have been d/or substance abuse information and that I id/or provider obtaining this release. If y medical and/or I-IIV-related and/or its.
Signature of Patient/P	arent/Legal Guardian		Date
Print Name		_	

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# Coordination of Care Form and Request of Confidential Information

	LIENT INFORMATION ame and/or Facility		Phone	Fax
Address				
City	State	Zip		
SECTION 2 — PA (Requestor) Patie	ATIENT INFORMATION nt Name:		DOB:	
SECTION 3 — CI	inical Information (To be p	provided to treating pro	ovider at IPG):	
Documents should	d be mailed or faxed to:			
ILacone Psychiati 301 South 9 <sup>th</sup> Stre Richmond, Texas Fax: 832-471-697	eet, Suite #118 77469			
BH Provider:			Date Faxed:	
my medical records records cannot be do revoke this authorize receiving treatment upon the termination answered. I underst can change my minauthorize IPG and the records records and the records records and the records reco	to include information related isclosed without my written cation at any time, except to that IPG, I understand that this n of treatment, unless I expre	It to all diagnosis and sub- consent unless otherwise ne extent that action has consent will automatical ss written revocation at a w release of my medical authorization by writing to sent to release information	pstance use. I understand provided for in the regula already been taken to cor lly expire one (1) year after an earlier date. Any questif and/or HIV and/or substate to the facility and/or providion including my medical a	er the revocation of this release or ions about this form have been nce abuse information and that I ler obtaining this release. I
Signature of Patie	ent/Parent/Legal Guardian		Date	
Print Name				

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Date:
Certificate for school or work:
was under my care on
Date:
If there are any further questions or concerns please contact me at the office number above
Physician comments:
Sincerely,
Roger Joe MD

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