Bay Pointe Behavioral Health Service, Inc.

Child ● Adolescent ● Adult Psychiatry

STATEMENT OF PATIENTS' RIGHTS

~ Every patient will be provided a written statement of patient rights and responsibilities at the time of the first appointment.
~ Every patient will be treated with dignity and respect.
~ Every patient will be assured that all patient information is kept confidential.
~ Every patient will be afforded all of his rights and privileges guaranteed by State and Federal laws.
~ Every patient has the right to know the name, professional status and function of those behavioral health care practitioners involved in his/her care and treatment.
~ Every patient will be provided with a complete, easily understood explanation of his/her condition.
~ Every patient will receive assistance with respect to knowing and understanding his/her benefits.
~ Every patient will be involved in decisions involving his/her treatment.
~ Every patient will be informed of the consequences of refusing treatment and/or not complying with prescribed treatment.
~ Every patient will be informed of the complaint, grievance and appeal processes should a dispute arise over treatment and/or claims.
~ Every patient will be afforded every reasonable consideration to accommodate his/her cultural, language or gender preferences.
~ Every patient will be provided with sufficient information to enable him/her to render informed consent to treatment except in emergencies.

INITIALS _____

IMPORTANT NOTICE ABOUT LABORATORY SCREENINGS

Some insurance companies and plans require that laboratory screenings (blood work, urine screens, etc.) be done only by certain companies. If your doctor prescribes laboratory work, check with your insurance company to see if there is a specific lab provider you must use. Lab requisition forms are available for both Lab Corp and Quest Diagnostic.

INITIALS _____

I have received this notice and understand that it is my responsibility to check with my insurance company before having laboratory work done.

CONSENT FOR RELEASE OF PATIENT INFORMATION FOR REIMBURSEMENT AND CONTINUITY OF CARE

I authorize Bay Pointe Behavioral Health Service, Inc. to release such social, demographic and diagnostic and therapeutic (including any treatment or test results for alcohol and/or drug abuse, or reportable communicable disease, including Acquired Immune Deficiency Syndrome or Human Immune-deficiency Virus Infection) for this period of inpatient hospitalization or outpatient treatment for one year from the date of this authorization to the following:

- My insurance carriers(s), the Social Security Administration, its intermediaries or carriers, or any party that is or may be liable for all or part of the hospital and and/or physician charges as may be necessary for the purpose of enabling the insurance carrier(s) or Social Security Administration to determine the benefits available to me for the services rendered by Bay Pointe Behavioral Health Service, Inc.
- Individuals, agencies, or facilities working with Bay Pointe Behavioral Health Service, Inc. staff as may be necessary to assist me with Discharge planning.
- The Social Security Administration and/or the Texas Rehabilitation Commission, if applicable, for use in determining my eligibility for disability benefits.
- I further authorize Bay Pointe Behavioral Health Service, Inc. to disclose patient-identifiable information about me for the purposes of seeking reimbursement assistance or for enrolling me in pharmaceutical patient assistance programs that may provide certain products free of charge or at a reduced rate. I understand that, in order to obtain reimbursement assistance or to determine my eligibility to participate in patient assistance programs, certain information about me, including, without limitation, the type and date of my medical diagnosis and treatment, my family income and my health insurance will need to be provided by Bay Pointe Behavioral Health Service, Inc. to the pharmaceutical manufacturer(s) or their agent(s) for the product(s) prescribed to treat my condition. I understand this information will not be used for any other purposes than that as described above.

INITIALS _____

I further authorize the use of photographic reproduction of this authorization in place of the original.
I understand that I may withdraw this authorization at any time but must do so in writing.

_____ **Patient Signature** (Patients over 18) _____ **Date** _____ **Parent/Guardian Signature** _____ **Date**

_____ **Witness** _____ **Date**

13310 Beamer Rd., Suite G, Houston, Texas 77089 ● Phone: (281) 480-2400 ● Facsimile: (281) 480-2407

CONSENT FOR DIAGNOSIS AND TREATMENT

Patient:_____ Chart #_____

I hereby authorize authorities of Bay Pointe Behavioral Health Services, Inc., and the doctor in charge of (the, my) case to administer such medications and perform such procedures as may be deemed necessary for the interest and care of: -

_____

(Name of Patient)

_____

Patient/other legally responsible person (Legal relationship to patient)

Reason patient is unable to sign: _____

_____

Address City State Zip

Emergency Phone Calls:

In the event of an emergency, call 911. For non-emergent calls, please call (281) 480-2400

Appointments and Billing:

PICTURE ID AND INSURANCE CARD(s) MUST BE PRESENTED AT EVERY VISIT

Please be aware that you are responsible for payment of your deductible, co-payment, and/or any other charges for service rendered that are not covered by your insurance.

You will be required to make your co-payment, unpaid charges, and/or deductible prior to being seen.

If you are unable to do so, you will be required to reschedule your appointment unless other arrangements for payment are made.

To Cancel an Appointment:

- Call (281) 480-2400 during normal business hours (Monday-Friday, 8 a.m. to 5 p.m., excluding holidays) at least 24 hours before your scheduled appointment.
- You must clearly state you are canceling your appointment and give the date and time of the scheduled appointment.
- Please record the name of the person who canceled your appointment, the date you called, and the time. You may be asked for this information if you call at a later date with questions regarding your appointment or rescheduling.
- If you do not cancel your appointment 24 hours in advance, you will receive a bill for the appointment. Insurance companies do not cover the cost of missed appointments and other charges; therefore, the entire cost will be your financial responsibility.
- Multiple cancellations in less than 24 hours and No Shows may cause your provider-patient relationship to end.
- If you have not been seen in over 6 months, your provider-patient relationship has ended.
    - Provider-patient relationship may resume once you are seen in our office by a provider.

As of January 1, 2014 the following charges will go into effect for all patients of Bay Pointe Behavioral Health Service, Inc.:

SERVICE:	CHARGE:
LETTERS	$150.00 per page
PHONE CALLS THAT REQUIRE CONTACT WITH DOCTOR (GIVE 24 HOURS FOR RETURNED PHONE CALLS)	$5.00 contact fee; plus $2.00 per minute
PHONE CALLS THAT REQUIRE CONTACT WITH DOCTOR ON WEEKENDS, HOLIDAYS, AND AFTER 5:00 P.M.	$20.00 contact fee; plus $5.00 per minute
CONFERENCE CALLS	$150.00 per 20 minutes
FORMS	$150.00 (1-3 pages); $10 per/page (for consecutive pages)
LOST / REWRITTEN PRECRIPTION	$20.00
CII PRESCRIPTION REFILL WITHOUT AN APPOINTMENT	$10.00
CANCELLED APPOINTMENT (WITHIN 24 HOURS)	$40.00 - $60.00
CANCELLED APPOINTMENT WITHOUT NOTICE	$60.00 – $80.00
NEW VISITS	$330.00 / $300.00 PROMPT PAY
ESTABLISHED VISIT FOLLOW-UP	$230.00 / $150.00 PROMPT PAY
PRIOR AUTHORIZATIONS	$25.00

***FOR LETTERS, FORMS, AND MEDICATIONS, PLEASE MAKE YOUR REQUEST 7 DAYS IN ADVANCE ***

If you have not been seen in our office by one of our providers in over 3 months, you may NOT receive a refill.

The services listed above will be billed directly to you. All fees are due prior to point of service. If other charges apply, you will be informed prior to service.

_____ _____ _____ _____

Patient Signature (Patients over 18) **Date** **Parent/Guardian Signature** **Date**

_____ _____

Witness **Date**

Bay Pointe Behavioral Health Service, Inc.

Child ● Adolescent ● Adult Psychiatry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY AND ACKNOWLEDGE RECEIPT BY YOUR SIGNATURE AT THE END OF THIS NOTICE.

If you have any questions about this Notice of Privacy, please contact a Bay Pointe Behavioral Health Service, Inc. Privacy Officer.

This notice describes how Bay Pointe Behavioral Health Service, Inc. may use and disclose your protected health information. The terms of this Notice of Privacy are effective April 14, 2003. This office will share patient health information as is necessary to provide quality care and receive reimbursement for those services as permitted by law. This office is required by the law to maintain the privacy of our patients' health information and to provide patients' with this Notice of Privacy Practices. This office will abide by the terms of this Notice so long as it remains in effect and we reserve the right to change the terms of this Notice of Privacy Practices as necessary. A copy of any revised notices will be available in this office, or, upon request to Bay Pointe Behavioral Health Service, Inc. - 1560 West Bay Area Boulevard, Suite 110, Friendswood, Texas 77546, a copy may be mailed to your address maintained on file.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

This office is committed to maintain the confidentiality of your health information. However, your health information may be used and disclosed as customary and reasonable for purposes of treatment, payment, and health care operations and pursuant to a signed authorization form. You have the right to revoke that authorization in writing unless any action has been taken in reliance on the authorization.

Treatment, Payment, and Health Care Operations. [Except as otherwise provided, or with your signed consent,] This office will use and disclose your health information for purposes of treatment, payment, and as otherwise necessary and permitted by law, for our health care operations. This may include disclosure to another health care provider who, at the request of your physician, becomes involved in your treatment, or for purposes of approval of reimbursement form your health plan.

Business Associates. At times, it may be necessary for us to provide your health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditations, legal services, etc. These business associates are required to properly safeguard the privacy of your health information.

Family and Friends. With your approval and using our professional judgment, your health information may be disclosed to designated family, friends, and others who are directly involved in your care or payment of your care. If you are unavailable, incapacitated, or in an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we many share limited health information with such individuals without your approval.

Appointments and Services. This office may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request, and we will accommodate your reasonable requests, to receive communications regarding your health information from us by alternative means or at alternative locations. You may request such as confidential communication in writing and may send your request to Bay Pointe Behavioral Health Services, Inc.

Other uses and disclosures of your individual health information, permitted or required by law, may be used without your consent or authorization.

1. Use or disclosure of your health information for any purposes required by law;
2. Use of disclosure of your health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigators;
3. Use or disclosure of your health information as required by law if we suspect child abuse or neglect; we may also release your individual health information as required by law if we believe you are a victim of abuse, neglect, or domestic violence;
4. Use or disclosure of your health information, if necessary, to the Food and Drug Administration;
5. Use or disclosure of your health information to your employer when we have provided health care to you at the request of your employer.
6. Use or disclosure of your health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
7. Use or disclosure of your health information if required by court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
8. Use or disclosure of your health information to law enforcement officials;
9. Use or disclosure of your health information to coroners and/or funeral directors consistent with law;
10. Use or disclosure of your health information if necessary to arrange an organ or tissue donation or transplant;
11. Use or disclosure of your health information if you are a member of the military as required by armed force services; we may also release your individual health information if necessary for national security or intelligence activities and
12. Use or disclosure of your health information to worker's compensation agencies.

YOUR RIGHTS

1. *Restrictions on Use and Disclosure of Individual Health Information.* You have the right to request restrictions on some of our uses and disclosures of your health information. These restrictions must be made in writing and signed by you or your representative. This office is not required to agree to your restrictions. We retain the right to terminate an agreed to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed to restriction by sending such termination notice to Bay Pointe Behavioral Health Service, Inc.

2. *Access to Individual Health Information.* You have the right to inspect any copy of your health information maintained by this office. All requests for access must be made in writing and signed by you or your representative. There is a fee of $20.00 per request if you request a copy of the information. There will also be a charge for postage if you request a mailed copy and, if requested, for preparation of a summary of the requested information. You may obtain a request for access (e.g. psychotherapy notes, information compiled for legal actions or information subject to prohibition by law). Depending on the circumstances, you may request a review of the decision to deny access. Please contact Bay Pointe Behavioral Health Service, Inc. for questions about access to your health information.

3. *Amendments to Individual Health Information.* You have the right to request in writing that your health information maintained by this office be amended or corrected. In certain cases, we may deny your request for amendment. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment. If we make an amendment, we may also notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain an amendment request form from Bay Pointe Behavioral Health Service, Inc. If we deny your request, you may submit a statement of disagreement to us and we may prepare a rebuttal that will be provided to you. These materials may be distributed in future requests to review your health information. Please contact Bay Pointe Behavioral Health Service, Inc. for questions about amendments to your health information.
4. *Accounting for Disclosures of Individual Health Information.* You have the right to receive an accounting of certain disclosures made by us of your health information after April 14, 2003. Requests must be made in writing and signed by you and your representative. Accounting request forms are available form Bay Pointe Behavioral Health Service, Inc. Accounting request forms are available from Bay Pointe Behavioral Health Service, Inc. The first accounting in any 12 month period is free; you will be charged a fee of $20.00 for each subsequent accounting request you request within the same twelve-month period. The right to receive this information is subject to certain exemptions, restrictions, and limitations.

281-480-2400
13310 Beamer Rd., Suite G
Houston, TX 77089

COMPLIANTS:

If you believe your privacy rights have been violated, you may file a compliant with Napoleon B. Higgins, M.D. You may also file a complaint with the Secretary of U.S. Department of Health and Human Services in Washington D.C. in writing. There will be no retaliation for filing a compliant.

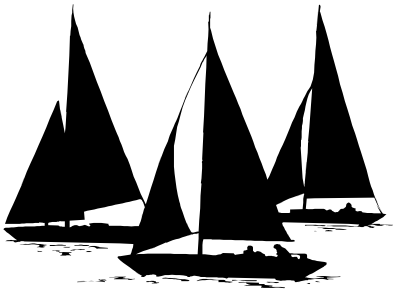
ADDITIONAL INFORMATION:

If you have questions or need additional assistance regarding this Notice, you may contact Napoleon B. Higgins, MD.-13310 Beamer Rd., Suite G
Houston, TX 77089
Phone: 281-480-2400

PATIENT SIGNATURE
_____

AUTHORIZED
REPRESENTATIVE (Title)
_____

Date:
_____



BAY POINTE BEHAVIORAL HEALTH SERVICE, INC.

NOTICE OF PRIVACY PRACTICES

Bay Pointe Behavioral Health Service, Inc.

Child ● Adolescent ● Adult Psychiatry

PATIENT INSURANCE BENEFIT INFORMATION

Date_____

Patient _____
Last First Initial

Address_____
Street City State Zip Code

Home Phone _____Cell Phone_____

SS#_____ Sex: M F Date of Birth _____ Age_____

Student Status: __Part Time __ Full Time __Non-Student E-Mail _____

Marital Status: **S W M D -** Spouse's Full Name_____
(If applicable)

Known Medical Conditions_____Allergies_____

Previous Surgeries/Illnesses _____Medications_____

Reason for Initial Visit_____

Referred to this office by _____

Responsible Party/Parent's Name (if different) _____

Address (if different)_____
Street City State Zip Code

Home Phone_____ **Relationship to Patient**_____

Emergency Contact Person_____**Phone**_____

Parent or Guardian's name (of Minor if applicable) _____

Occupation/Student_____**Employer/School**_____**WorkPhone**_____

**********Your Insurance**********

Primary Company_____ Address_____

Policy #_____ Group #_____ Phone_____

Subscriber_____ DOB _____ Relationship to Subscriber_____

Secondary Company_____ Address_____

Policy #_____ Group #_____ Phone_____

Patient/Responsible Party **x**_____Date_____

Witness_____ Date_____

(PLEASE COMPLETE ENTIRE PAGE. THANK YOU)

13310 Beamer Rd., Suite G, Houston, Texas 77089 ● Phone: (281) 480-2400 ● Facsimile: (281) 480-2407

Bay Pointe Behavioral Health Service, Inc.

Child • Adolescent • Adult Psychiatry

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

I, _____, _____ _____, for the purpose of
(Patient Name-Print) (Patient D.O.B.) (Patient Social Security #)

coordinating care, authorize **Bay Pointe BHS, Inc.**, to release information indicated in the "Consent" portion of this form to:

If you do not have a Primary Care Physician, please initial here _____ and sign below.

PCP Name: _____

PCP Phone: _____ **PCP Fax:** _____

PCP Address: _____

(Street) (City) (State) (Zip)

Information for PCP:

For Office Use Only:

The patient was seen by me on (date): _____ for (Diagnosis) _____

Treatment Plan: _____

For Psychiatrists Only:

The following medication(s) was/will be started: (list medications and dosage) _____

_____

_____ Medication was not indicated _____ Patient refused medication _____ Psychotherapy suggested before trying med.

Please call me at **(281) 480-2400**, to discuss this case further or if you need any other information.

_____

(Provider signature) *(Provider Printed Name)*

CONSENT

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months form the date of signature, unless another date is specified. I have read and understand the above information and give my consent:

Patient please check one:

( ) To release any applicable mental health/substance abuse information to my primary care physician
( ) To release only medication information to my primary care physician
( ) I do not give my consent to releasing any information to my primary care physician.

Patient Signature (Patients over 18) **Date**

Parent/Guardian Signature (Patients under 18) **Date**

Witness Date

Notice To Recipient Of This Information: This information has been disclosed to you from records which are protected by federal (42 CFR Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

13310 Beamer Rd., Suite G, Houston, Texas 77089 ● Phone: (281) 480-2400 ● Facsimile: (281) 480-2407

-OVER-

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's
Initials

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of _____ at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

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_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between _____ and staff and _____.
(Healthcare provider's name) *(Patient's name)*

_____ _____
Patient or Legal Representative Signature/Date/Time Relationship to Patient

_____ _____
Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal representative (circle one)* fully understands what I have explained.

_____
Healthcare Provider Signature/Date/Time

_____ copy given to patient _____ original placed in chart
initial initial

Optional National Emergency Crisis Language

I understand that due to the state of the current national emergency crisis, telehealth is offered by _____ to appropriate patients in an effort to comply with federal and state mandates of isolation and social distancing as an effort to provide protection to everyone.

The purpose of this form is to obtain your consent for a telehealth visit with one of our healthcare providers at the office of _____.

The purpose of this visit is for the care of _____during the national emergency.
(condition/treatment)

JI2355 3/20

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS, and accreditation requirements, if any, and legal requirements of your individual state(s).