Michelle Magid, M.D.
1600 W. 38th St., Ste. 404
Austin, TX 78731
Phone 512.454.7741

PATIENT INFORMATION

Today's Date: _____

Name _____Date of Birth_____

Sex _____ Age _____Marital Status _____

Address _____

Home # _____ Cell _____ Work _____

May we leave a message? (yes/no) Home _____ Cell _____ Work _____

Preferred pharmacy _____

Pharmacy Address_____

Pharmacy Phone _____ Fax _____

Emergency contact _____ Relationship _____

Address _____

Home # _____ Cell _____ Work _____

Referred by _____

Address _____

Phone _____ Fax _____

Primary care physician _____

Address _____

Phone _____ Fax _____

Primary Insurance _____ Policy # _____

Group # _____ Insured Name _____

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OFFICE POLICIES

Informed Consent for Psychiatric Services

It is my pleasure to have the opportunity to work with you. Please read this document carefully as it contains important information about my professional services and business policies. Before signing, please feel free to ask me any questions. Once this document is signed, it will constitute a binding agreement between us.

Services

I am a board-certified psychiatrist in the state of Texas. As a physician, I am able to prescribe medication if we both agree this is a necessary and appropriate treatment for you. I am also an experienced provider of psychotherapy and may recommend this form of treatment alone, or in addition to medication. All treatment requires an active effort on your part.

At the conclusion of your initial assessment, I will offer you some impressions of what our work may entail and possible treatment recommendations. You should assess this information and your own initial impressions to decide whether you feel comfortable working with me. If at any time you have questions regarding my professional training or clinical procedures, please feel free to discuss them with me.

Confidentiality

Trust and safety are paramount in the treatment of mental health conditions. Therefore, I take confidentiality very seriously. Moreover, federal law prohibits me from releasing information about our work without your written permission. However, there are a few exceptions:

1. If I believe you could harm yourself or others
2. If I suspect child or elder abuse
3. If a court subpoenas your records
4. If an on-call physician in this office needs information to treat you appropriately in my absence

Emergencies

During business hours, please contact our office at (512) 454-7741. My staff can get in touch with me or the on-call physician for our office. After business hours please contact our 24-hour answering service at (512) 404-9076. In the case of extreme emergency, please call 911, or seek immediate care at your nearest emergency department. The emergency department staff can involve the on-call physician as needed.

Prescription Refills

If you begin taking a medication it is very important that you are safely monitored for its effectiveness and side effects. You will be given ample medication and refills until your next appointment. It is your responsibility to schedule follow-up appointments before you run out of your prescription. In return, you will find that I am conscientious about the cost of medical care and do not request unnecessary visits. If I do refill a medication between visits, it is usually my policy to prescribe only enough medicine until the next visit. Refills for triplicate medication (typically stimulants for attention deficit disorder) between appointments will be completed for a charge of $15.00.

Contacting You

It is your responsibility to keep your contact information up to date. I cannot be your treatment provider if I am not able to contact you. If your information changes, please contact our office at (512) 454-7741 and update our staff as soon as possible.

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OFFICE POLICIES cont.

Contacting Me

I encourage you to contact me if you have questions or concerns about your treatment. You may call me during office hours and leave a non-confidential voicemail or message with my office manager. I will not interrupt appointments to take calls except in absolute emergencies. However, I will make every effort to return calls as soon as possible.

Payment and Fees

Initial evaluations are $285.00, 50 minute appointments for psychotherapy or combination therapy-medication are $200.00. 25 minute follow-up appointments are $130.00, and 15 minute follow-up appointments are $100.00. Payment is due in full upon arrival before each session so that we can keep your account current. We will strive to complete all work during our scheduled sessions. However, I may charge on a prorated basis for other professional services you may require such as report writing, telephone conversations lasting longer than 10 minutes, prior authorizations, and consultations with other professionals that you have requested. Our office accepts cash, check, MasterCard, and Visa for your convenience. There is a $25 charge for any checks that are returned unpaid by your bank.

Cancellations and Missed Appointments

All office visits are by appointment only. Cancellations must be made 24 hours in advance (Friday for a Monday appointment) by calling my office. Failure to do so will result in the full charge for the missed appointment. Patients covered under the Seton Health Plan will be required to pay the full fee for missed appointments (not just the copay). Repeated no-shows or late cancellations will be carefully discussed and may be cause to discontinue treatment.

Insurance

The only insurance for which I am a provider is the Seton Health Plan. For all others, I will provide you with the necessary information to file your claim with your insurance company.

Again, I appreciate the opportunity to be of service to you. If you have any questions, concerns, or suggestions regarding my practice, please discuss them with me as I am always eager to hear your comments and will gladly answer any questions. Your signature below indicates that you have read the above and consent to the terms of this contract.

I have read and understand the office policies regarding financial arrangements, fees, and charges for missed appointments or late cancellations. I voluntarily consent to treatment and understand that informed consent ends with the termination of the professional relationship. I may terminate this relationship at any time.

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice: We are required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know, how we are permitted to:

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.
We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

Uses and Disclosures of PHI: We may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission.
Examples of our use of your PHI:
For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.
For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.
For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization: We are permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

- For our use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called an ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care.

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ Birth Date: _____

PATIENT RECORD DISCLOSURES

In general, the Health Insurance Portability and Accountability Act (HIPPA) privacy rule gives individuals the right to request a restriction on uses and disclosures 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 alternative means, such as correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (please give us first preference):

- ☐ Home Phone: _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Mobile Phone: _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Phone: _____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call-back number only

Patient Signature: _____ Date: _____

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PHQ-9 PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? (Please circle the number in the column that fits)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
	Add 3 columns	_____ +	_____ +	_____

Total of 3 Columns*:* _____

If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____

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MOOD DISORDER QUESTIONNAIRE

Patient Name: _____ Date: _____

1.	Has there ever been a period of time when you were not your usual self and (while not using drugs or alcohol) ...		
	...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?	Yes	No
	...you were so irritable that you shouted at people or started fights or arguments?	Yes	No
	...you felt much more self-confident than usual?	Yes	No
	...you got much less sleep than usual and found you didn't really miss it?	Yes	No
	...you were much more talkative or spoke faster than usual?	Yes	No
	...thoughts raced through your head or you couldn't slow you mind down?	Yes	No
	...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes	No
	...you had much more energy than usual?	Yes	No
	...you were much more active or did many more things than usual?	Yes	No
	...you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?	Yes	No
	...you were much more interested in sex than usual?	Yes	No
	...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes	No
	...spending money got you or your family into trouble?	Yes	No

2.	If you checked YES to more than one of the above, have several of these ever happened during the *same period of time*?	Yes	No
3.	How much of a *problem* did any of these cause you -- like being unable to work; having family, money, or legal troubles; getting into arguments or fights? No Problem Minor Problem Moderate Problem Serious Problem		

4.	Draw a line connecting any (blood) relative to any problem (this doesn't have to be neat): *Grandparents* *Parents* *Aunts/Uncles* *Brothers/Sisters* *Children* Suicide Alcohol/drug problems Mental Hospital Depression Problems Manic or bipolar

5.	Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	Yes	No

For Physician Use Only: TOTAL SECTION 1: _____
Section 1. 7 yes responses *Section 2. Yes* *Section 3. Moderate/Serious*

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I give permission for the following two agencies/persons to share my protected health information:

Name: Michelle Magid, M.D.	Name_____
Address: 1600 W. 38th St., #404	Address: _____
City/State/Zip: Austin, TX 78731	City/State/Zip: _____
Phone: (512) 454-7741	Phone: _____
Fax: (512) 451-7245	Fax: _____

☐ All Records ☐ Psychiatric Evaluation ☐ Progress Notes

☐ Psychological Testing ☐ Medication Information ☐ Lab Tests/Medical Imaging

☐ Other _____

I give special permission to share the following information:

☐Psychotherapy Notes ☐Alcohol/Drug Abuse

Approximate Dates of Service:

☐Any ☐From: _____ To: _____

Purpose for Disclosure (Please Check):

☐Continuity of Care ☐ At My Request ☐Other: _____

This authorization can be cancelled at any time by request, in writing, but the cancellation will not affect any disclosures already made prior to receipt of cancellation notice. This office cannot control how the protected health information will be used by the agency/person who receives it under this authorization.
Unless cancelled or otherwise specified, this authorization will expire one year from date of signature.

Other Specified Expiration Date: _____

Patient Signature: _____ Date: _____

Printed Name: _____