BHC-Behavioral Health Consultants, Inc.
9525 Katy Fwy #312 | Houston, Texas 77024
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CONFIDENTIAL INFORMATION SHEET
RETURNING PATIENT FORMS

This information is to help us better understand you and your situation. Please fill it out as completely as you can.
All information will be held in strict confidence.

PATIENT INFORMATION: **DATE:** ____ / ____ / ____

Name**:** _____ Date of Birth: ____ / ____ / ____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

Preferred Method of Communication: ☐ Home Phone ☐ Mobile ☐ Email Gender: ☐ Male ☐ Female

Marital Status: _____ Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Specify

Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ Pacific Islander ☐ White ☐ Decline to Specify

Preferred Language: _____ Referred by: _____

Smoking Status: ☐ Never Smoker ☐ Former Smoker ☐ Light Smoker ☐ Heavy Smoker

INSURANCE INFORMATION *(skip if self-pay)*:

Primary Insurance: _____ Phone: _____

Employer: _____ Policy #: _____ Group #: _____

Subscriber: _____ SSN: ____ - ____ - ____ Subscriber's DOB: ____ / ____ / ____

Secondary Insurance: _____ Phone: _____

Employer: _____ Policy #: _____ Group #: _____

Subscriber: _____ SSN: ____ - ____ - ____ Subscriber's DOB: ____ / ____ / ____

NEXT OF KIN / RESPONSIBLE PARTY:

Name**:** _____ Email: _____

Relationship to Patient**:** _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

1. **I, the undersigned, accept financial responsibility for payment of all fees at the time of visit, unless other arrangements have been made with the Accounting Department.**
2. **AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize the release of any information regarding my condition or treatment to insurance company.**
3. **AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER: I hereby authorize the payment of insurance benefits from my insurance company to my provider.**

SIGNED:_____ DATE:_____
(patient or legal guardian)

PRIMARY DOCTOR INFORMATION:

Name: _____ May we contact him/her? ☐Yes ☐No

Address:_____ City: _____ Zip: _____

Phone: _____ Fax: _____

TREATMENT HISTORY:

Have **YOU** ever had? Please check all applicable boxes:

☐Cancer
Type:_____
☐Heart Attack/Coronary
☐Artery Disease
☐Rheumatic Fever
☐Heart Failure
☐High blood pressure
☐High cholesterol
☐Stroke
☐Diabetes
☐Gallstones
☐Liver Disease
☐Hepatitis/Jaundice
☐Ulcer Disease
☐Heartburn/Reflux
☐Asthma
☐Seizures

☐Emphysema
☐Pneumonia
☐Tuberculosis
☐Positive TB Skin Test
☐Osteoporosis
☐Arthritis
☐Gout
☐Frequent Bladder Infection
☐Kidney Stone
☐Kidney Disease
☐Polio
☐Chicken Pox
☐Infectious Mono
☐Anemia
☐Frequent Sinus Infection

☐Glaucomo
☐Thyroid Trouble
☐Hives
☐Depression
☐Head Injury
☐Broken Bones
☐Blood Transfusions
☐Sexually Transmitted Diseases:Herpes. HIV
☐Gonorrhea
☐Chlamydia
☐Syphilis
☐Intravenous drug abuse
☐Needle Injury
☐Mumps
☐Migraines

☐Prostate Enlargement
☐Cystic Fibrosis
☐Malaria
☐Other:
_____
_____

IMMUNIZATIONS:
☐Measles, Mumps and Rubella Vaccine
☐Chicken pox vaccine
☐Hepatitis B vaccine
☐Influenza vaccine
☐Pneumococcal vaccine
☐Tetanus booster

Past Surgical History. Please check all applicable boxes and enter year:

☐Eyes (Laser or Vision Corrected) _____
☐Eyes (Cataract/Glaucoma _____
☐Ears _____
☐Sinus/Nasal Septum _____
☐Tonsils/Adenoid _____
☐Thyroid _____
☐Heart _____
☐Stomach _____
☐Varicose Veins _____

☐Gall Bladder _____
☐Appendix _____
☐Intestine/Colon _____
☐Hemorrhoids _____
☐Hernia _____
☐Breast _____
☐Uterus/Hysterectomy _____
☐Ovaries _____
☐Spinal Surgery/Neck _____
☐Prostate _____

☐Spinal Surgery/Back _____
☐Orthopedic (Hips/Knee/ Shoulder/Feet/Hands) _____
☐C-section _____
☐Vasectomy _____
☐Tubal Ligation _____
☐ Other:
_____ _____
_____ _____

Has anyone in your **FAMILY** ever had? Please check all applicable boxes:

☐Cancer
Type: _____
☐Diabetes
☐Cardiac Dysrythmia
☐Congestive Heart Failure
☐Cornary Artery Disease
☐Valvular heart Disease
☐High Blood Pressure
☐High Cholesterol
☐Stroke
☐Kidney stones
☐Kidney disease

☐Dialysis
☐Chronic lung Disease
☐Tuberculosis
☐Rheumatoid Arthritis
☐Thyroid trouble
☐Osteoporosis
☐Cystic Fibrosis
☐Asthma
☐Peptic Ulcer
☐Gallstones

☐Crohn's / colitis
☐Alzheimer's
☐Alcoholism
☐Bleeding tendency
☐Anemia
☐Gout
☐Depression
☐Mental illness
☐Seizures
☐Migraine headaches

Allergies (List all medication and drug allergies):

_____

_____

Medications (List all medications prescribed and taken for the last 12 months):

Name	Dosage	Schedule

Do you **CURRENTLY** feel or have? Please check all applicable boxes:

GENERAL
☐Fatigue
☐Fever
☐Weight Gain >10 lbs
☐Weight Loss >10 lbs

SKIN
☐Nail Changes
☐New Lesions

HEENT
☐Double Vision
☐Eye Pain
☐Eye Redness
☐Decreased Hearing
☐Earache
☐Ear Ringing
☐Nose Bleeds
☐Dry Mouth
☐Hoarseness
☐Oral Ulcers
☐Sore Throat

NECK
☐Neck Pain
☐Swollen Glands

BREAST
☐Breast Mass
☐Breast Pain
☐Nipple Discharge
☐Skin Changes

RESPIRATORY
☐Chronic Cough
☐Decreased Exercise Tolerance
☐Difficulty Breathing
☐Coughing Up Blood
☐Sputum Production
☐Wheezing

CARDIOVASCULAR
☐Chest Pain
☐Leg Pains with walking
☐Leg Swelling
☐Night Awakening due to trouble breathing
☐Palpitations
☐Shortness of Breath

GASTROINTESTINAL
☐Abdominal Pain
☐Change in Bowel Habits
☐Constipation
☐Diarrhea
☐Nausea
☐Vomiting
☐Rectal Bleeding
☐Trouble Swallowing

URINARY
☐Increased Frequency
☐Blood in Urine
☐Loss of Bladder Control
☐Urinary Retention
☐Urethral Discharge
☐Incontinence

MUSCULOSKELITAL
☐Muscle pain
☐Stiffness
☐Back pain
☐Joint pain
☐Redness of joints
☐Swelling of joints

NEUROLOGIC
☐Loss of Bowel Control
☐Dizziness/Vertigo
☐Fainting
☐Seizures
☐Numbness
☐Tingling
☐Tremor

PSYCHIATRIC
☐Anxiety
☐Depression
☐Nervousness
☐Stress
☐Memory Loss

ENDOCRINE
☐Appetite Changes
☐Cold Intolerance
☐Increased Thirst
☐Increase Urination
☐Hair Changes
☐Sexual dysfunction
☐Sweating

HEMATOLOGY
☐Easy Bruising
☐Enlarged Lymph Nodes
☐Prolonged Bleeding

I certify the information provided is correct and I authorize services to be provided to the above named patient.

_____ _____

Patient /Legal Guardian Signature **Date**

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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	Extremely difficult
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 or staying asleep, or 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 figety 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	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* 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 _____
- Extremely difficult _____

A2663B 10-04-2005

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

GENERAL INFORMATION AND OFFICE POLICIES (Office Copy)

Appointment and Service Fee

Initial Evaluation may last from 45 mins to 60 mins. Follow up treatment and medication management last about 10-15 minutes.

You will be charged **$60.00** for **no shows** and **late cancellations**. Appointments must be cancelled at least **24 hours** prior to the reserved time if you are unable to keep it. You may text the office during normal business hours. A 24-hour answering service is also available 7 days a week to take messages, for your convenience. You may also leave a voicemail or email the office.

We accept all forms of payment for your convenience. Payment is expected at the time of each visit unless prior arrangement has been made. Penalty for returned check is **$35.00**. Patient/Responsible party is ultimately responsible for any amount not covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, the client and provider can negotiate a payment schedule.

I understand and accept the policies concerning both the cancellation of appointments and payment for services. Furthermore I agree that successive missed appointments are subject to termination of our doctor-patient relationship.

_____ _____

Patient/Responsible Party Signature Date

Confidentiality

Your patient records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent. Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by the patient. In an emergency situation when you, the patient, are at imminent risk of death or serious medical consequence, your provider may release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of abuse. Be advised that email and mobile phone conversations are not secure or guaranteed of privacy because they can be intercepted, hence confidentiality may be potentially compromised.

I understand and accept the policy concerning my confidentiality.

_____ _____

Patient/Responsible Party Signature Date

Letters/Medical Reports/Correspondence/Disability Forms

Any reports, letters, forms or correspondences that are deemed not medically necessary for your treatment are additional tasks to the doctor. Therefore, we charge for these additional tasks. Please allow 7 to 10 days for completion of your requests after we have all the appropriate releases and/or information to complete the forms. Below is some general information about medical correspondence.

We must have a signed release from the patient to release information to anyone else. This includes family members, other doctors, insurance companies, and employers. Please make sure you sign our release form at the time of your request. We must have clear instructions as to what method the information will be conveyed to the other party, i.e. fax, mail, telephone. We need complete fax numbers, phone numbers and/or addresses. The charge for a letter and other medical records-related requests may range from $25 to $100, depending on its complexity. The cost of reproducing records is $1.00 per page.

I understand and accept the above office policy.

_____ _____

Patient/Responsible Party Signature Date

Telehealth Policy and Text Messaging Consent

Texas law defines telepsychiatry as remote mental health services provided by a healthcare provider licensed in Texas. As such, **both the provider and patient must be physically located within the state of Texas during telepsychiatry visits.** Should you choose to partake in telepsychiatry: you voluntarily agree to receive evaluation, diagnosis, and treatment through audio, video, and/or electronic communication. You understand that telepsychiatry has limitations compared to in-person visits, including **possible technological interruptions** and the provider's **inability to perform certain physical assessments**. You also understand that patients on stimulant medications **must have an in-person appointment at least once every 12 months**.

By providing your phone number, you consent to receive SMS and/or iMessage® text messages from BHC-Inc. for appointment reminders, marketing messages, and general two-way communication about your treatment and psychiatric relationship. SMS and/or iMessage® text messages may be sent directly from your provider's phone or via BHC-Inc.'s designated text line. Neither BHC-Inc. nor the provider are responsible for delays in communication resulting from the use of SMS or iMessage®.

I understand and accept the policy concerning telehealth visits and text messages.

_____ _____

Patient/Responsible Party Signature Date

GENERAL INFORMATION AND OFFICE POLICIES (Patient Copy)

(Please keep for your records)

Appointment and Service Fee

Initial Evaluation may last from 45 mins to 60 mins. Follow up treatment and medication management last about 10-15 minutes.

You will be charged **$60.00** for **no shows** and **late cancellations**. Appointments must be cancelled at least **24 hours** prior to the reserved time if you are unable to keep it. You may text the office during normal business hours. A 24-hour answering service is also available 7 days a week to take messages, for your convenience. You may also leave a voicemail or email the office.

We accept all forms of payment for your convenience. Payment is expected at the time of each visit unless prior arrangement has been made. Penalty for returned check is **$35.00**. Patient/Responsible party is ultimately responsible for any amount not covered by health insurance. Additional cost may be incurred for use of assessment instruments. In the event of an accrued balance, the client and provider can negotiate a payment schedule.

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I understand and accept the policy concerning telehealth visits and text messages.

BHC–BEHAVIORAL
HEALTH CONSULTANTS, INC

REFILL REQUEST POLICY (OFFICE COPY)

We do not accept refill requests directly from pharmacies. Requests must be submitted by the patient one week before current medication supply runs out.

How to submit a request:

- **Email:** frontdesk@bhchouston.com
- **Prescription Line:** 713-464-2595
- **Text:** 832-961-3356
- **MYIO Patient Portal:** https://www.valant.io/myio/BHCInc/login

Required Information: To avoid delays, please include all of the following in your request

- Patient name, date of birth and phone number
- Dates of last and next scheduled appointments
- Pharmacy name, address, and phone number
- Medication name, dosage, and directions

Processing Time: Please allow 1–3 business days for processing. Requests sent after 12:00 noon will be processed the following business day. Requests sent on Friday after 12:00 noon, over the weekends, or during holidays will be processed the next working day. An automated text message will be sent once your request has been processed.

Appointments: Refills are issued to cover you until your next scheduled visit. Patients must have an appointment on file and be seen at least once every quarter (or sooner if required by your provider). Patients on stimulant medications must have an in-person appointment at least once every 12 months. ***Patients are responsible for scheduling appointments. No partial refills will be provided if an appointment was missed or canceled.***

Account: All outstanding balances must be settled before a refill is issued.

Fees: A $10 administrative fee applies to all C-II drug requests made outside of a scheduled appointment, except for Medicaid patients. To avoid this fee, please schedule a monthly visit or contact your insurance provider to see if a 90-day fill is permitted for controlled medications.

Pharmacy and Insurance:

Once a refill is sent, it is managed by the pharmacy. Please contact your pharmacy or insurance provider directly regarding medication release or coverage. If a medication requires prior authorization, please contact your insurance first to identify the reason for denial and their specific requirements for coverage before notifying our office. This service is currently offered free of charge. The provider retains the right to deny any refill request.

Name	Signature	Date

BHC–BEHAVIORAL
HEALTH CONSULTANTS, INC

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NOTICE OF PRIVACY PRACTICES
(Office Copy)

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we shar
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

By signing below, I acknowledge receiving a copy of the "Privacy Notice" of BHC-Behavioral Health Consultants, Inc. describing my right to privacy of my protected health information (PHI) under the Federal HIPAA Privacy Law, as follows:

- **How my PHI may be used and disclosed,**
- **My privacy rights regarding my PHI,**
- **The medical practice's obligations concerning the use and disclosure of my PHI.**

Patient Name/Guardian _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this notice but was unable to do so as documented below:

Date:	Initials:	Reason:

NOTICE OF PRIVACY PRACTICES (Patient Copy)

(Please keep for your records)

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.**

YOUR RIGHTS

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information
in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.
Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.
Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see
that we're complying with federal privacy law.
Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

BHC's No Show Pre-Authorized Charge Form

I authorize BHC-Behavioral Health Consultants, Inc. to keep my signature on file and to charge my Credit Card listed below for:

☐ The one time amount of $ **60.00 in the event that I fail to cancel my scheduled appointment and failed to provide 24 hours notice.**

I understand that this form is valid for one year unless I cancel the authorization through written notice to the service provider.

Customer Name:_____

Cardholder Name:_____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Account Number:_____

Expiration Date:_____ Card Verification Number: _____

Cardholder Signature: X_____ Date: _____

USE OF PRE-AUTHORIZED CHARGE FORMS

This form is a pre-authorization to charge credit card payments to your customers. You must still complete the actual credit card charges, including getting an authorization for each transaction.

The information on this form is to be used to fill out your charge slips, as is authorized by the cardholder for payment of future or ongoing visits.

1. The name of the service provider-your practice or business (as it appears on your card imprinter) must be filled in the top line.
2. The cardholder must choose one of the three payment schedules indicated by each of the three boxes:
    i) Charges not paid by insurance, not to exceed a designated amount, for either the current visit, or for all visits within a year.
    ii) Recurring charges of a specific amount, to be charged on a scheduled basis between two designated dates.
    iii) A total fee, of a designated amount to be charged to the customer's card one time.
3. Personal information must be completed by the provider, stating the customer's name, cardholder's name, card type, account number and expiration date. Please be careful to note that the cardholder's card expiration date does not extend beyond the "ending date" for any recurring charges.
4. The cardholder must sign and date the form at the bottom.
5. The cardholder receives the top copy, and the bottom two copies are retained by the service provider. (If there is any discrepancy regarding the charges, the provider has the second copy to supply to the cardholder's bank.)
6. The form is valid for use for one year, or until the cardholder cancels authorization through written notice to the service provider.