

Clinic Location & Program: Dallas Las Colinas Plano CD-IOP Counseling Svcs Work Returns

Patient Name _____ DOB ____/____/____ Age ____ Sex _____

SS# ____ - ____ - ____ Race _____ Marital Status _____ Religion _____

Patient Address:

Address _____

City/State/Zip _____

Home # (____) _____

Cell # (____) _____

Email Address: _____

Employer Name _____

Address _____

City/State/Zip _____

Work # (____) _____

Occupation _____

Next of Kin

Name _____

Address _____

City/State/Zip _____

Home # _____ Work # _____

Relationship _____

Person to Notify in case of emergency

Name _____

Address _____

City/State/Zip _____

Home # _____ Work # _____

Relationship _____

Guarantor (Insured / Responsible. Party)

Name _____

Address _____

City/State/Zip _____

Home # _____

Cell # _____

Email: _____

Relationship _____

Social Security # ____ - ____ - ____

DOB: _____

Employer Name _____

Address _____

City/State/Zip _____

Work # _____

Occupation _____

Primary Insurance Info.

Insurance Co. _____

Address _____

City/State/Zip _____

Telephone # _____

Subscriber Name _____

Relationship _____

Policy # _____

Group # _____

Secondary Insurance Info.

Insurance Co. _____

Address _____

City/State/Zip _____

Telephone # _____

Subscriber Name _____

Relationship _____

Policy # _____

Policy # _____

How did you learn about Green Oaks? _____



GREEN OAKS HOSPITAL
7808 Clodus Fields Drive • Dallas, TX 75251

REGISTRATION FORM

PATIENT IDENTIFICATION



ADMINS

Conditions of Admission and Consent for Outpatient Care

In this document, "**Patient**" means the person receiving treatment. "Patient Representative" means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I", "you", "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor"

"**Provider**" means the hospital and may include healthcare professionals on the hospital's staff and/or hospital-based physicians, which include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, Anesthesiologists, Hospitalists, certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf

Legal Relationship between Hospital and Physicians. Most or all of the physicians performing services in the hospital are independent and are not hospital agents or employees. Independent physicians are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent physicians.

- 1. Consent to Treatment.** I consent to the procedures which may be performed during this hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered as ordered by the Provider. I consent to allowing students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and/or hospital staff This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome ("AIDS"), and Hepatitis, if a physician orders such test(s) for diagnostic and/or treatment purposes. I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the Hospital to test a patient who may have exposed a health care worker to HIV without obtaining the person's consent. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.
- 2. Consent to Photographs, Videotapes and Audio Recordings.** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's quality improvement and/or risk management activities. I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.



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CONDITIONS OF ADMISSION & CONSENT FOR OUTPATIENT CARE



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3. Financial Agreement. In consideration of the services to be rendered to Patient, Patient or Guarantor individually promises to pay the Patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the Patient's account. Some special items will be priced separately if there is no price listed on the Charge Master. An estimate of the anticipated charges for services to be provided to the Patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

Professional services rendered by independent contractors are not part of the hospital bill. These services will be billed to the Patient separately. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

The hospital will provide a medical screening examination as required to all Patients who are seeking medical services to determine if there is an emergency medical condition without regard to the Patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, Patient and Guarantor understand that if Patient does not qualify under the hospital's charity care policy or other applicable policy, Patient or Guarantor is not relieved of his/her obligation to pay for these services.

If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill an insurance company offering coverage, but may not be obligated to do so. Regardless, I agree that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the Patient or Guarantor. I agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements.



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4. Third Party Collection. I acknowledge that the Providers may utilize the services of a third party Business Associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing. During the time that the medical account is being serviced by the EBO Servicer, the account shall not be considered delinquent, past due or in default, and shall not be reported to a credit bureau or subject to collection legal proceedings. When the EBO Servicer's efforts to obtain payment have been exhausted due to a number of factors (for e.g., Patient or Guarantor's failure to pay or make a payment arrangement after insurance adjustments and payments have been credited, and/or the insurer's denial of claim(s) or benefits is received), the EBO Servicer will send a final notice letter which will include the date that the medical account may be returned from the EBO Servicer to the Provider. Upon return to the Provider by the EBO Servicer, the Provider may place the account back with the EBO Servicer, or, at the option of the Provider, may determine the account to be delinquent, past due and in default. Once the medical account is determined to be delinquent it may be subject to late fees, interest as stated, referral to a collection agency for collection as a delinquent account, credit bureau reporting and enforcement by legal proceedings.

I also agree that if the Provider initiates collection efforts to recover amounts owed by me or my Guarantor, then, in addition to amounts incurred for the services rendered, Patient or Guarantor will pay, to the extent permitted by law: (a) any and all costs incurred by the Provider in pursuing collection, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the Provider.

5. Assignment of Benefits. Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. Patient understands that any payment received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during the admission.

I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer- sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("Responsible Party") for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.



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CONDITIONS OF ADMISSION & CONSENT FOR OUTPATIENT CARE



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I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

- 6. Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.
- 7. Private Room.** I understand and agree that I am (or Guarantor is) responsible for any additional charges associated with the request and/or use of a private room.
- 8. Outpatient Medicare Patients.** Medicare does not cover prescription drugs with only a few exceptions. According to Medicare regulations, I acknowledge that I am responsible for any drugs furnished to me while an outpatient that meet Medicare's definition of a prescription drug. These drugs are also referred to as self-administered drugs, as they are usually self-administered but they may be administered to me by hospital personnel. Medicare requires hospitals to bill Medicare Patients or other third party payers for these drugs. Medicare Part D beneficiaries may submit a paper claim to the Medicare Part D Plan for possible reimbursement of these drugs in accordance with Medicare Drug Plan enrollment materials.
- 9. Communications About My Healthcare.** I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.
- 10. Consent to Telephone Calls for Financial Communications.** I agree that, in order for you, or your EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that you or your EBO Servicer and collection agents may contact me by telephone at any telephone number I have provided or you or your EBO Servicer and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization, the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded /artificial voice messages and / or use of an automatic dialing device, as applicable.
- 11. Consent to Email or Text Usage for Discharge Instructions and Other Healthcare Communications.** If at any time I provide an email or text address at which I may be contacted, I consent to receiving discharge instructions and other healthcare communications at that email or text address from the Providers. These discharge instructions may include, but not be limited to: post-operative instructions, physician follow-up instructions, dietary information, and prescription information. The other healthcare communications may include, but are not limited to communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.



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12. Other Acknowledgements.

Personal Valuables. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless

deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars (\$500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the Patient. The hospital is not responsible for the loss or damage of cell phones, glasses or dentures or personal valuables unless they are placed in the hospital safe in accordance with the terms as stated above.

Weapons/Explosives/Drugs. I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings located anywhere on hospital property, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my Patient Representative designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity and gender expression, and sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other Patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital's complaint resolution system.

Records Retention. Unless my records are involved in litigation, the Provider may dispose of my medical records 10 years after the date of my last treatment here, or, for minors, the later of 10 years after the date of the patient's last treatment or the date of the patient's 20th birthday.

Additional Provision for Admission of Minors/ Incapacitated Patient. **1**, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.



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Insurance Network. I acknowledge that I have received notice that, based on the information available at this time, this facility IS/IS NOT a participating provider under my health or insurance plan(s). I also acknowledge that I understand that some of the physicians, including facility-based physicians (e.g., radiologists, anesthesiologists, pathologists, neonatologists, and/or emergency department physicians), or other providers who may provide services to me during my admission, procedure, or other services, may not be participating providers under my health or insurance plan(s), and may bill me for services that are not paid by my health or insurance plan(s).

13. **Patient Self Determination Act.** I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). Please initial or place a mark next to one of the following applicable statements:

I executed an Advance Directive and have been requested to supply a copy to the hospital	I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive	I have not executed an Advance Directive and do not wish to execute one at this time
--	--	--

14. **Notice of Privacy Practices.** I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ (Initial)

15. **Consent to Authorize Use of Email and Text for Patient Billing and Financial Obligations.** By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving **information** relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and links to hospital Patient billing information.

Acknowledge: _____ (Initial) I consent to use of email for Patient billings and financial obligation purposes.

Acknowledge: _____ (Initial) I consent to use of text for Patient billings and financial obligation purposes.

16. **Acknowledgement:** I have been given the opportunity to read and ask questions about the information contained in this form, **specifically** including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

Acknowledge: _____ (Initial)



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**CONDITIONS OF ADMISSION & CONSENT
FOR OUTPATIENT CARE**

PATIENT IDENTIFICATION



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17. **Acknowledgement of Notice of Patient Rights and Responsibilities.** I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

Acknowledge: _____ (Initial)

Date:	1, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.
Time:	
Patient/Patient Representative Signature:	Witness Signature and Title:
<p>X _____</p> <p>If you are not the Patient, please identify your Relationship to the Patient.</p> <p>(Circle or mark relationship(s) from list below):</p> <p>Spouse Parent Legal Guardian Neighbor/Friend Sibling Healthcare Power of Attorney Guarantor Other (please specify):</p> <p>_____</p>	<p>X _____</p> <p>Additional Witness Signature and Title: (required for Patients unable to sign without a representative or Patients who refuse to sign)</p> <p>X _____</p> <p>HCA Texas COA-COS 03.17.15</p>



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**CONDITIONS OF ADMISSION & CONSENT
FOR OUTPATIENT CARE**



COAS

PATIENT IDENTIFICATION

Patient Rights

I have been given information and instructions about my Patient Rights. My Patient Rights include the right to make medical decisions, including the right to accept or refuse medical treatment, participate in my plan of care and receive care in a safe setting, free from verbal or physical abuse or harassment. I have received a copy of the Patient Rights Booklet. I have received information on how to complete a Mental Health Treatment Declaration regarding my mental health care treatment. I have also received information about the Hospital's grievance process.

Organ Donation

I understand that I may donate any of my organs or tissues for transplantation by completing an anatomical gift form. If I have signed an organ donor card, I understand that the hospital has requested a copy of this card.

Do Not Resuscitate (DNR)

It is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative measures or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive or Health Care Power of Attorney. Your agreement with this policy by your signature below does not revoke or invalidate any current Advance Directive or Health Care Power of Attorney.

I have read this document and I understand it. I have signed this Condition of Admission Addendum voluntarily. I have received no promises from anyone about the results of any medical/mental health treatment services.	
<input type="checkbox"/> Patient is medically unable to sign the Condition of Admission Addendum	<input type="checkbox"/> Patient Refused to Sign
Date	Time
Patient/Parent/Guardian/Conservator X	If other than patient, indicate relationship
Spouse (If married/available) X	Witness X



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**CONDITION OF ADMISSION
ADDENDUM**

PATIENT IDENTIFICATION



COA

Consent for Use and Release of Information

I authorize the release of my healthcare information for purposes of communicating results, findings and care decisions to my family members and other responsible for my care or designated by me. I will provide those individuals with a password or other verification means as specified by the Hospital.

I (as the parent or guardian, spouse, guarantor, agent of the patient) permit the Hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information for purposes treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. I also permit the Hospital to release my healthcare information to my employer, _____ or employer's designee when

(Name of Employer)

the services delivered are related to a work-related injury. If the patient is covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carrier for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurses' notes, consultations, psychological and/or psychiatric reports and discharge summary. This consent specifically includes information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, and/or infectious diseases including, but not limited to blood-borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I acknowledge and authorize that data from my patient records will be accessible to all health care providers participating in my care or treatment, including, without limitation, physicians, nurses, and other health care workers at the Hospital, home health agencies, ambulance companies, and/or such other health care agencies involved in my care during and after transfer or discharge from the Hospital.

I acknowledge that my medical records will be utilized in the Hospital's (and the Hospital's affiliates') utilization review, performance improvement, peer review and other similar processes or studies. I also acknowledge that my medical records will also be made available to governmental agencies or authorities to the extent authorized or required by law. Information contained in my medical records may be extracted or compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel and physicians involved in my care and their offices. I also acknowledged that should I be treated at another facility in the area affiliated with Hospital, my medical records may be made electronically available to the other facility and physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities, which are not affiliated with the Hospital, and affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I authorize the release Hospital or its authorized representative to contact me by telephone after my discharge by surveyors of the Gallup organization or a similar organization on the Hospital's behalf conducting patient satisfaction surveys and other studies.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device that I may receive.

I authorize that my religious preference may be released to local religious organization(s) if requested by me.

Date	1, hereby certify I have read, and fully and completely understand this Authorization for Release of Information / Healthcare Information, and that I have signed this Authorization for Release of Information / Healthcare Information knowingly, freely, and voluntarily.		
Time	<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	<input type="checkbox"/> Patient is medically unable to sign the Consent for Use and Release of Information. <input type="checkbox"/> Patient Refused to Sign	
Patient/Parent/Guardian		If other than patient, indicate relationship	
Spouse (if Married/Available)		Witness (to Signature only)	

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Consent for Use & Release

- ADMIN -

PATIENT IDENTIFICATION

I hereby authorize my psychiatrist and/or members of Green Oaks Hospital treatment team to discuss my treatment with the following:

NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	RELATIONSHIP	PHONE NUMBER Home: Work:	RESCINDED
NAME	Therapist	PHONE NUMBER Office:	RESCINDED
WOULD YOU LIKE YOUR TREATMENT MANAGER TO CONTACT YOUR PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No PRIMARY CARE PHYSICIAN NAME	Primary Care Physician	PHONE NUMBER Office:	RESCINDED
WOULD YOU LIKE YOUR TREATMENT MANAGER TO CONTACT YOUR OUTPATIENT PSYCHIATRIST? <input type="checkbox"/> Yes <input type="checkbox"/> No OUTPATIENT PSYCHIATRIST NAME	Psychiatrist	PHONE NUMBER Office:	RESCINDED

I understand that I can revoke this authorization at any time except to the extent that action has been on this authorization.

DATE	TIME
PATIENT / PARENT / GUARDIAN / CONSERVATOR X	IF OTHER THAN PATIENT, INDICATE RELATIONSHIP
SPOUSE (If Married / Available) X	WITNESS (To Signature Only) X



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AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION



COA

PATIENT IDENTIFICATION

Appointments

Clinic hours are 9:00 - 5:00 Monday -Friday. Therapists have evening appointments after 5:00 on certain days of the week. Patient appointments are scheduled by calling the office during regular business hours.

If you need to cancel an appointment we ask that you provide a minimum of 24 hour notice. All appointments which are not canceled prior to 24 hours will be charged \$25.00. If there are 3 or more scheduled appointments missed without cancellation you could be discharged.

Emergency Situations / After Office Hours

In an emergency, call 911 or go directly to the nearest emergency room.

Financial Policy

Payment is due at the time of service. Patients are responsible for their co-payments and/or deductibles at the time services are rendered.

Insurance

Your insurance policy is a contract between you and your insurance company, therefore, we cannot guarantee payment of your claims or accept responsibility of negotiating claims with insurance companies or other persons. In the event of denials, errors or non-covered services, the patient is responsible for all services rendered and we will seek payment from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility. We do not guarantee that payment will be authorized for services; therefore, this office is not responsible for any adverse payment decisions or misuse of information. It is your responsibility to notify us of any change in your insurance status. If you have two insurance carriers, please advise and provide a copy of **both** cards.

I have read and understand the above office procedures and practices.

Patient Signature


Date

Time

Witness

Date

Time



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**COUNSELING SERVICES - PLANO
CLINIC INFORMATION**

PATIENT IDENTIFICATION



PINS

FLOURISHING SCALE

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Below are 8 statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by indicating that response for each statement.

- 7 - Strongly Agree
- 6 - Agree
- 5 - Slightly agree
- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

- ___ I lead a purposeful and meaningful life
- ___ My social relationships are supportive and rewarding
- ___ I am engaged and interested in my daily activities
- ___ I actively contribute to the happiness and well being of others
- ___ I am competent and capable in the activities that are important to me
- ___ I am a good person and live a good life
- ___ I am optimistic about my future
- ___ People respect me

Patient initials (Please print): _____ Date: _____

Office Use Only - Circle One Program: WR CS PHP Administration: Pre Post # Sessions _____



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FLOURISHING SCALE



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PATIENT IDENTIFICATION