Meredith M Hake, APRN, PMHNP-BC
Real Hope Real Help
2300 Highland Village Road, Ste. 210
Highland Village, TX 75077
Ph: (972) 966-1079 | F: (972) 767-0755
Patient@realhoperealhelp.net

Minor Patient Intake Form

Patient Information:

Patient Name (Last, First, Middle): _____

Age: _____ Date of Birth: _____ Gender: _____

Address: _____

Primary Phone #: _____ Secondary Phone #: _____

Email Address: _____ Preferred Method of Contact: _____

Race/Ethnicity: _____

School: _____ Grade: _____

Parent Information:

Parent/Guardian's Name _____ Date of Birth: _____

Gender: _____ Relationship to Patient: _____ Marital Status: _____

Home Address: _____

Employer: _____ Address: _____

Other Parent/Guardian's Name: _____ Date of Birth: _____

Gender: _____ Relationship to Patient: _____ Marital Status: _____

Home Address: _____

Employer: _____ Address: _____

Preferred Pharmacy: _____

Address: _____

Referral Source: _____ Specialty: _____

Referral Phone #: _____

CONSENT FOR TREATMENT OF MINOR/DEPENDENT CHILD: I certify that I am the (father, mother, managing conservator, legal guardian (circle one) of the above-named child, and I hereby give my authorization and informed consent for the above-named child to receive psychiatric diagnostic and treatment services from Real Hope Real Help. I further certify that I have the legal authority to authorize and consent to this treatment.

_____

Print Name Signature Today's Date

Patient: _____

CONSENT FOR ALTERNATE CAREGIVER/EMERGENCY CONTACT (optional): If you consent to allow Real Hope Real Help to discuss your protected health information with anyone other than yourself or the parent/legal guardian for minor patients, please list them below. Your signature will indicate your consent to this communication until you withdraw your consent in writing.

Emergency Contact Name: Phone Number:

Relationship to Patient:

Print Name Signature Today's Date

Assignment of Insurance Benefits for Payment from Your Insurance Carrier/Provider

In-Network Insured: If you wish for Real Hope Real Help to file for direct In-network reimbursement by your insurance company, please provide the information requested below. If insurance Holder or Financially Responsible Party is same as previous contact listed, you only need to fill in the name.

Insurance Carrier: Primary Subscriber's Name:

Date of Birth: Gender: Phone Number:

Primary Subscriber's Address:

Employer: Employer's Address:

Financially Responsible Party's Name: Date of Birth:

Gender: Relationship to Patient: Marital Status:

Home Address:

Employer: Address:

I hereby assign payment of medical benefits by: (Insurance Company): _____ to Real Hope Real Help. I also authorize the release of any medical information requested by the above-named insurance or managed health care company. The assignment will remain in effect until revoked by me in writing (a photocopy of this assignment is to be considered as valid as the original). I understand that I am financially responsible for all charges whether paid, or not, by said insurance except to the extent that a contract between the provider and a managed health care company might limit that financial responsibility.

Print Name Signature Today's Date

Patient: _____

Developmental History

Child's Name:_____ Relationship to Child: _____

Date of Birth: _____ Gender: _____

School: _____ Grade: _____

Language(s) Spoken at Home: _____

What are the current concerns that prompted seeking treatment? _____

_____

_____

_____

Family Information:

Mother's Name: _____ Father's Name: _____

Please list all siblings and any other persons residing with the family:

Name:_____ Age:____ Gender:____ Relationship to Child:_____

Name:_____ Age:____ Gender:____ Relationship to Child:_____

Name:_____ Age:____ Gender:____ Relationship to Child:_____

Name:_____ Age:____ Gender:____ Relationship to Child:_____

If parents are divorced or separated, who has custody of the child? _____

How often does this child see the other parent? _____

List Sports, hobbies, or Activities your child enjoys: _____

_____

_____

Is there any additional information you would like to share about your child. (information about relationships with friends/siblings/family members, past concerns, family moves, etc.): _____

_____

_____

_____

_____

_____

Patient: _____

Pregnancy & Early Childhood:

Where there any complications with pregnancy or delivery: _____

_____

Did patient meet expected developmental goals, any delays, concerns, etc.: _____

_____

Were there any medical complications that affected development: _____

_____

Any significant changes or traumas in early childhood: _____

_____

Medical Information:

Check all that apply:

[ ] Hearing problems [ ] Tubes [ ] Frequent ear infections [ ] Overly sensitive to sound

[ ] Vision problems [ ] Wears glasses

[ ] Any significant childhood diseases or chronic illnesses (please explain): _____

_____

[ ] Head Injury, concussion, or loss of consciousness (please explain): _____

_____

Is your child currently under the care of a physician (please explain): _____

_____

Please list any allergies your child has:

Drugs: _____

Food: _____

Environmental: _____

Please list any current medications or over the counter supplements:

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Family Medical or Behavioral Health History: _____

_____

_____

Please describe any hospitalizations or surgeries and the approximate date: _____

_____

Patient: _____

Temperament, Behavior, and Relationships:

Check all that describe your child now:

[ ] Sad	[ ] Happy	[ ]Anxious/worried	[ ] Tearful
[ ] Moody	[ ] Other: _____		
[ ] Hides feelings	[ ] Short Attention Span	[ ] Recovers quickly from setbacks	
[ ] Lacks self-control	[ ] Withholds Affection	[ ] Easily Overstimulated	[ ] Impulsive
[ ] Poor sleep habits	[ ] Overreacts to Problems	[ ] Gets Angry Easily	[ ] Even Disposition
[ ] Requires Constant Supervision	[ ] Poor Eating Habits	[ ] Picky Eater	[ ] Aggressive
[ ] Upset by Changes in Routine			

Academic Information:

Please list all the schools your child has attended: _____

_____

What are your child's current subject strengths: _____

What are your child's current subject weaknesses: _____

Has your child repeated any grades? [ ]Yes [ ] No, If yes, please explain: _____

Is your child in any gifted or special education classes? _____

Is your child in any afterschool or day care programs? _____

What time does your child usually go to bed on school nights? _____

What are your child's current skill *strengths?* Check all that apply.

[ ] None	[ ] Completing assignments	[ ] Turning in homework	[ ] Concentration
[ ] Memorizing	[ ] Pleasing the Teacher	[ ] Reading Speed	[ ] Vocabulary/Expression
[ ] Intelligence	[ ] Understanding Concepts	[ ]Papers and Reports	[ ] Paying attention
[ ] Handwriting	[ ] Spelling	[ ]Test Preparation	[ ] Checks Work Carefully
[ ] Organization	[ ] Working Hard or Not Giving Up		
[ ] Other: _____			

What are your child's current skill *weaknesses?* Check all that apply.

[ ] None	[ ] Completing assignments	[ ] Turning in homework	[ ] Concentration
[ ] Memorizing	[ ] Pleasing the Teacher	[ ] Reading Speed	[ ] Vocabulary/Expression
[ ] Intelligence	[ ] Understanding Concepts	[ ]Papers and Reports	[ ] Paying attention
[ ] Handwriting	[ ] Spelling	[ ]Test Preparation	[ ] Checks Work Carefully
[ ] Organization	[ ] Working Hard or Not Giving Up		
[ ] Other: _____			

Welcome to Real Hope Real Help

Thank you for choosing Real Hope Real Help as your or your child's mental health provider. It is a difficult, yet courageous decision to share your thoughts, feelings, and burdens with another human being. I am a Psychiatric Mental Health Nurse Practitioner licensed and trained to practice in the field of psychiatry, offering medication management and brief psychotherapy. I am governed by various laws and regulations and by the code of ethics of my profession. I will use my best knowledge and skills to help you.

My primary goal is patient centered care focused on comprehensive psychiatric treatment. I may encourage, educate, direct, or provide psychological and social support as well as make recommendations for other resources or interventions as appropriate and individualized for each patient. Please ask any questions regarding your treatment or progress. I sincerely hope working together will lead to positive outcomes including ongoing personal growth and development for you or your child.

Our first few sessions will involve an evaluation of your situation and needs. I will take notes during our visits, and you may find it useful to take your own notes. If you have questions about my suggestions or procedures, we should discuss them whenever they arise. If you could benefit from a psychological treatment I cannot provide, I will do my best to help you find the resources to seek out the treatment. You have the right to ask me about other treatments, their risks, and their benefits.

Medication Management

Medication management is not precise. It is impossible to determine in advance who will respond to a particular medication. I will use my knowledge and available research to provide suggestions based upon your symptoms and diagnoses. I may also decide to perform genetic screening to determine how your body metabolizes medications to aid in the decision-making process. I will notify you of possible risks, benefits, and side effects of the medications we discuss and choose. We will not know how you will respond until you try a medication.

Supportive Psychotherapy

In addition to medications, we will include supportive psychotherapy. I use a Lifestyle Psychiatry approach, and use a combination of supportive, educational, interpersonal, and CBT informed skills based care. Research shows with many mental health issues the combination of medications and therapy works better and quicker than either modality alone.

Supportive therapy is not like a traditional visit to a medical doctor. Instead, it requires the patient to be actively involved in the visit. For therapy to be the most successful, you will need to practice coping skills and read, listen to, or access various resources during our sessions and at home.

The benefits of therapy have been proven over and over in hundreds of well-designed research studies. Therapy often leads to improved relationships, better communication, rebuilding of trust, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. Sometimes psychological services are provided primarily to prevent further deterioration of your mental or emotional status, which is considered maintenance treatment.

Psychotherapy may have risks as well as benefits. Since our visits may involve discussing unpleasant aspects of life, you or your child may experience uncomfortable feelings such as sadness, anxiety, guilt, anger, frustration, loneliness, and helplessness. Sometimes, during a session a major

life decision is made, or life secrets are shared. All this information is held with the utmost confidentiality unless you disclose you are planning to hurt yourself or someone else. Sometimes the patient may temporarily feel worse after discussing difficult situations and emotions.

I am not a licensed therapist, and supportive psychotherapy is not meant to take the place of psychotherapy delivered by a licensed therapist. Many times a patient will need to seek the services of a licensed therapist in addition to receiving supportive therapy. If we feel additional or more intensive therapy is needed, I will work with you to find a therapist for you to contact. There are many different types of therapy and part of my training is to identify the resources available and types of therapy needed to help patients with the problems they hope to address.

Appointments and Cancellation Policy

Appointments are scheduled in advance by calling the office at 972-966-1079 or made at the end of your appointment. Your initial evaluation will take place over the first 2 to 3 appointments which will be an hour in length, and ideally no more than a week between appointments. During your first appointment there will be a lot of information to cover, and we may not have time to go into detail regarding everything that has happened in the past. It is important to finish your new patient paperwork prior to your first appointment to allow time for this to be reviewed.

As you continue in treatment, we may decide to change your appointments to 30 minutes in length depending on how you are responding to care. These appointments will range from weekly, to monthly, to every few months. If you are stable and we are not making changes to the treatment plan, I will need to see you every 3 months. If you have been in an inpatient psychiatric hospital or if it has been more than 5 months since your last visit, you will need to schedule a re-evaluation.

Appointments are a commitment to our working together. We agree to meet and be on time. If I am unable to start on time because I am with another patient, I ask for your understanding. If someone is struggling, an appointment can take a few minutes longer than the scheduled time. To ensure that each patient is given their allotted appointment time and high-quality care is given, it is important for each scheduled patient to arrive to each visit on time. If you are going to be more than 15 minutes late, your appointment will need to be rescheduled.

I understand that sometimes you may need to cancel or reschedule your appointment. If you are unable to keep your appointment, I ask that you give us at least 24-hour, or one business day, notice. You can cancel appointments by calling our office at 972-966-1079. You may also leave a voice message at our office phone number with at least a 24-hour notice. **The charge for not showing up for an appointment, or for an appointment cancelled without 24-hour notice is $85.** This charge will be waived only in the case of an emergency. (Initials: _____)

Emergencies

Real Hope Real Help is not an emergency clinic, and services are provided on an appointment only basis. Should an issue occur that cannot wait until our next available appointment, please call the office at 972-966-1079. I will make every attempt to return your call the same day. If you are unable to reach me and feel you cannot wait for me to return your call, contact 911, your family physician, or the nearest emergency room and ask for the psychiatrist or psychologist on call. (Initials: _____)

Prescriptions and Refills

In general refill requests are best handled at the time of your appointment, or during regular clinic hours. Refills are routinely handled through electronic transmission. **When you have 1 week remaining on a prescription, contact your pharmacy and request a refill.** They will contact our office. Please allow five (5) business days for all refill requests once you have contacted your pharmacy. **Refill requests outside of clinic hours, on weekends, and on holidays will be assessed a $50 fee.**

Refills will only be provided for active patients of the clinic. A patient will only be considered an active patient if they keep their appointment and have follow-up appointments scheduled as recommended by the provider. After the passage of 4 months without contact between the provider and the patient, the patient may be considered an inactive patient. Inactive status may also be instituted after 2 missed scheduled appointments with less than a 48-hour cancellation notice. **If you are not current with your appointments, your refill request may be denied.**

If medication has been prescribed continuously by the provider and inactive status occurs, a maximum of one month of medication may be prescribed while the patient schedules an appointment at their earliest convenience or finds an alternative healthcare provider. (Initials: _____)

Contacting Me

Although I am typically in the office during normal business hours, I am unable to take calls or check messages when I am with a patient. When I am unavailable, you may leave a message for non-emergency situations at 972-966-1079. I make every effort to return calls on the same day they are received, but your call will be returned within 24 to 48 hours, except for weekends and holidays. If a phone call exceeds 10 minutes, we reserve the right to charge a pro-rated hourly rate for every 15 minutes the clinician is on the phone with a patient or family member. Telephone fees are not covered by your insurance and charges associated with them are solely the patient's responsibility.

If an urgent situation arises after office hours, you may call and possibly leave a message at 469-993-9167. However, if an emergency exists and you cannot wait for a return call, go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary. Please be aware that I strive to conduct clinical conversations only within sessions, not over the telephone or email.

Patient: _____

Billing and Financial Policies

Real Hope Real Help provides the following policies with the intent to build a clear and trusting relationship with the patient and their families. It is the hope that these policies will assist in avoiding misunderstandings concerning payment for professional services and provide the highest quality of care. All charges are for time reserved for your scheduled appointment or used in your ongoing care. Appointment fees are based on both duration of appointment and complexity.

Our fees are as follows:

Initial Psychiatric Diagnostic Evaluation	$570
Ongoing Care Visit, 17-37 minutes, low complexity	$275
Ongoing Care Visit, 17-37 minutes, moderate complexity	$330
Ongoing Care Visit, 38-52 minutes, moderate complexity	$375
Ongoing Care Visit, 53-60 minutes, moderate complexity	$420
All Other Services, $570/hour, prorated in 10-minute increments	$570/hour
Late Cancellation, less than 24-hour notice	$85
Missed Appointment Fee	$85
Contacting NP after hours for Emergency Medication Refills	$50
*Discounted fees are available for self-pay patients.	

Please initial next to each policy listed below:

_____ **Professional Fees:** My hourly rate is $570.00. Professional services such as telephone conversations lasting longer than 10 minutes, meetings with other professionals you have authorized, writing letters, completing reports, preparing records or treatment summaries, and time spent performing other services you may request of me will be billed accordingly. Payment schedules for other professional services will be agreed to when they are requested.

_____ **Insurance Billing:** We will file claims with your primary Insurance companies with which we are contracted. We do not file claims to secondary policies. If you are insured through a deductible plan and your deductible has not been met, the office will collect the fee insurance companies allow. Deductible fees, Co-insurance and Co-payment amounts are due at the time of service. If services are requested that are not covered by insurance, it will be the responsibility of the patient/parent to pay for these services.

_____ **Non-covered Services:** If your insurance company does not pay for services rendered those balances will become the patient's/parent's responsibility. Insurance filing is processed by software provided by TheraSoft. Before receiving services, you must verify that your clinician is a participating provider for your insurance company. You can do this by calling the number on the back of your insurance card and having them verify that your clinician is in-network with your specific policy. Should it come back that the services are not in-network, you will be financially responsible for the out-of-network services rendered.

_____ **Insurance Changes:** It is your responsibility to provide the office with any and all changes to your insurance, billing address, and contact information. If new insurance information or any changes are not received within 3 business days of your visit, you will be financially responsible for services rendered.

_____ **Payment for children of divorced parents:** Co-payments, co-insurance, deductibles, and self-pay balances are due at the time services are rendered. The parent or guardian present with the patient should be prepared to pay at the appointment. Claims will be filed to your primary insurance.

_____ **Insufficient Funds:** An account paid by check which is returned by the bank unpaid for any reason will be charged $60 in addition to the original balance. The office may also seek additional legal remedies under Texas law. Payment must be made by cashier's check, cash, or credit card.

_____ **Statements:** Statements will be sent to the billing address you provide. Payment is due upon receipt of the statement. If you have any questions or dispute the validity of the balance, it is your responsibility to contact the Billing Department. Accounts not paid within 30 days of the statement date are considered past due. If you have difficulty paying your bill, payment arrangements may be made; however, it is your responsibility to contact the Billing Department and discuss a payment plan within 30 days to keep your account from being past due. If your account is over 60 days past due and you have not made payment arrangements, your outstanding balance will be sent to a collection agency.

_____ **Missed Appointments, Late Cancelations:** We ask that you arrive 10 minutes prior to every scheduled appointment. If you are unable to make your scheduled appointment we ask that you give the office 24 hour/one business day notice. There are patients waiting to be scheduled for an appointment, and when you fail to show up for your appointment or do not cancel 24-hours in advance, this slot cannot be filled with another patient needing services. Missed appointments, without 24-hour/one business day prior cancellation notice, will assess a "no call, no show/late cancellation" fee of $85.00. Patients arriving more than 15 minutes late to their appointment will be required to reschedule and will also incur a "no show/late cancellation" fee. If there are 3 or more no shows or late cancellations, you must call the Office Manager to discuss the matter before another appointment may be scheduled. Work-In appointments for emergencies or other special circumstances will be available but must be discussed prior to the appointment. The same "no call, no show/late cancellation" rules will apply to these appointments. We will allow one (1) no call, no show/late cancellation without charge, but after that for any reason an appointment is missed without 24-hour notice will be a fee of $85.00.

_____ **Medical Records:** Copies of psychiatric medical records are not typically printed and provided to the patient. For records to be released, you must complete and sign an Authorization to Release Information/Records. There will be a $25 fee for records requests unless another professional requests the records.

_____ **Letters/Documentation:** The fee will be determined by the amount of time spent to complete the request. Please allow 2-3 business days for all forms and letters to be processed.

_____ **Court Fees:** If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for their professional time, even if they are called to testify by another party. You will be charged the hourly fee for preparation time, travel time, and any time spent with an attorney/clerk for preparation. Travel costs will also be billed from door-to-door.

Professional Records

The laws and standards of my profession require I keep treatment records. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your clinical record or a summary can be prepared for you. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend you review them in my presence so we can discuss the contents.

Audio and Visual Recording

You acknowledge and agree by signing this information and consent form, neither you nor myself will record any part of your telepsychiatry visit. You further acknowledge I object to your recording any portion of your visit without my consent. (Initials:____)

Defamation

By signing this consent form, you agree you will not make defamatory comments about myself to others or post defamatory commentary about me on any website or social media site. In the event defamatory remarks about me are made by you, or others acting in concert with you, you further consent by signing this intake and consent form to allow me to use confidential information necessary to rebut or defend against or prosecute claims for the defamation.

Cooperation of Patient

You shall provide me with any changes in address, phone number, insurance, contact information, or business affiliation during the time period which my services are required. You will comply with all reasonable requests made in connection with therapeutic treatment. I may set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including and without limitation: Your refusal to comply with treatment recommendations, your failure to pay fees or balances in a timely manner in accordance with this consent form, and in accordance with the professional responsibility requirements to which the undersigned provider is subject. It is further understood and agreed upon such termination of services, any deposits remaining in the account will be applied to any balance remaining owed for fees and/or expenses and any surplus then remaining shall be refunded to you.

Confidentiality and Consent

In general, the law protects the privacy of all communications between a patient and a provider. In most situations, information about your treatment can only be released to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult with other professionals about a patient. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultation is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel it is important to our work together. I will note all consultations in your Clinical Record.
- As part of cost control efforts, an insurance company will sometimes ask for some

information regarding symptoms, diagnoses, medications and other treatment methods. It will become part of your permanent medical record. I will notify you if this should occur and what information the company requested. Please understand I have no control over how these records are handled by the insurance company. My policy is to provide only as much information as the insurance company needs to pay your benefits. These situations rarely occur, and I will make every effort to discuss this with you prior to taking any action, unless I believe notifying you may put your health in jeopardy.

- If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or contact family members or others who can help provide protection. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient. I will take any threats seriously whether I am informed by the patient or someone they know.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved In a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any Information without your (or your legal representative's) written authorization, or a court order. If you are Involved In or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient In order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation Is being sought.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make **a** report to the appropriate governmental agency, usually the Department of Protective and Regulatory Services. Once such a report Is filed, I may be required to provide additional information.
- If I determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful In Informing

you about potential problems, It is important that we discuss any questions or concerns that you may have now or In the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Patient Rights

HIPAA provides you with several new or expanded rights about your Clinical Record and disclosures of protected health Information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected Information disclosures are sent; having any complaints you make about my policies and procedures recorded In your records; and the right to a paper copy of this Agreement, the attached notice form, and my privacy policies and procedures.

Minors and Parents

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. Because privacy in psychotherapy is often crucial to successful progress, for children between the ages of 16 and 18, if necessary, I may request an agreement from the patient and his/her parents that the parents give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Consent for Treatment

I have voluntarily chosen to receive treatment with Real Hope Real Help. I authorize and request my provider to complete psychiatric examinations, treatments, and/or diagnostic procedures which are designated to be helpful. My provider makes no guarantees about the outcome of my treatment and care. I agree to fully participate in my treatment.

Patient: _____

"Welcome Letter" Signature Form and Patient-Provider Agreement

I, the patient (or his/her parent or guardian), understand I have the right not to sign this form. My signature below indicates I have read and discussed this agreement; it does not indicate I am waiving any of my rights. I understand any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about any of the subjects discussed in this document, I can talk with Meredith Hake, MSN, APRN, PMHNP-BC about them and she will do her best to answer them. I understand after treatment begins, I have the right to withdraw my consent for treatment at any time, for any reason. However, I will make every effort to discuss my concerns about my progress before ending treatment. I understand no specific promises have been made to me by this provider about the results of treatment, the effectiveness of the procedures used by this provider, or the number of sessions necessary for treatment to be effective. I know I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged a fee for that appointment. I have read, or have had read to me, the issues and the points in this document. I have discussed any points I did not understand and have had questions, if any, fully answered. I agree to act according to the points covered in this document. I hereby agree to enter into treatment with this provider, Meredith Hake, MSN, APRN, PMHNP-BC and to cooperate fully and to the best of my ability as shown by my signature below. I acknowledge I have received a copy of my authorization for my own records. I also agree to the following terms and conditions:

- I will be honest and report progress (or lack thereof), side effects, or dangerous thoughts immediately when the session begins.
- I will follow all recommendations regarding medications and, particularly, protections for safety.
- I will inform Real Hope Real Help of all hospitalizations for psychiatric reasons (including Intensive Outpatient or Partial Hospitalization Programs).
- I understand my provider may call 911 if necessary to protect my safety. This may occur without discussion if the patient does not immediately present a plan for safety when deemed clinically reasonable by the provider.
- I understand my prescription may not last between appointment intervals. I understand I need to contact my pharmacy to have a refill request sent when I have 7 days of medications remaining. I understand if emergency refills are authorized by the provider after-hours (nights/weekends) I will be assessed a $50 fee.
- I understand all fees associated with paperwork, documentation, and letters completed and written on my behalf are not insurance reimbursable and must be paid before paperwork will be completed.
- I understand all fees are expected to be paid at the date and time services are rendered. Nonpayment may result in a referral to another provider.
- I understand my provider will evaluate my progress on an ongoing basis. If improvement is not significant as would be expected for my condition, the provider may refer me to a new clinic. The provider does not believe it is ethical to continue treatment with no clear results and restoration to previous functioning or reasonable maintenance of clinical status. Sometimes a new approach may be needed in certain circumstances.

_____	_____	_____
Patient/Guardian Printed Name	Patient/Guardian Signature	Date
_____	_____	_____
Provider Name	Provider Signature	Date

Meredith M Hake, APRN, PMHNP-BC
Real Hope Real Help
2300 Highland Village Road, Ste. 210
Highland Village, TX 75077
Ph: (972) 966-1079 | F: (972) 767-0755
Patient@realhoperealhelp.net

Credit Card Guarantee of Payment

I understand that Real Hope Real Help will be billing me for therapy, evaluations, or psychological testing services. With this form, I give Real Hope Real Help permission to charge my credit card for any services that have not been paid by me within 24 hours of a missed therapy appointment or late cancellation, or within 60 days of billing. If services have not been paid within 30 days, Real Hope Real Help will notify me in writing of the outstanding payments.

I understand that Real Hope Real Help uses the credit card processing company Emdeon. On my credit card statement the charge will appear as it is coming from that company and not from Real Hope Real Help.

I understand that I must complete this form/agreement to be seen as a patient in this practice.

Patient Name: _____

Cardholder Name: _____

Cardholder Billing Address: _____

_____

Type of Card (Circle One): Amex Discover Master Visa

Credit Card Number: _____

Security Code: _____ Exp. Date: _____

Signature: _____ Date: _____

Meredith M Hake, APRN, PMHNP-BC
Real Hope Real Help
2300 Highland Village Road, Ste. 210
Highland Village, TX 75077
Ph: (972) 966-1079 | F: (972) 767-0755
Patient@realhoperealhelp.net

Consent for Electronic Communication

Unencrypted email is not a secure farm of communication. There is some risk that individually identifiable health information and other sensitive or confidential information that may be contained in such emails may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive emails from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

Patient Name: _____

My email address is: _____

Please check all that apply:

- ☐ I consent and accept the risk in receiving information via email/text message. I understand I can withdraw my consent at any time.
- ☐ I **DO NOT** consent to receiving any information via email/text. I understand that I can change my mind and provide consent later.
- ☐ I consent to receiving information about office announcements via email/text.

_____	_____	_____
Patient/Guardian Printed Name	Patient/Guardian Signature	Date

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Informed consent and agreement for Telepsychiatry/Telehealth Services

Definition: Per the Texas Occupations Code, Chapter 111, **Telehealth service** means a "health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology."
Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

- **Telepsychiatry** is the delivery of behavioral health services using interactive technologies (use of audio, video, or other electronic communications) between a practitioner and a patient who are not in the same physical location.
- A computer and a webcam with a microphone **are required** to video conference using a HIPAA compliant online company adherent to telemedicine practice principles.
- The interactive technologies used in telebehavioral health incorporate network and software security protocols to protect the confidentiality of patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

For any telehealth appointment to take place, please go through and understand each item in this informed consent form. If you have questions, please do not hesitate to let us know and we will be more than happy to answer them for you.

1. I understand that I/my child am voluntarily participating in a treatment using telehealth technology rather than an in person, face to face, visit.
2. I understand that this appointment/treatment will not be the same as an in-person, face to face, patient/healthcare provider visit because I/my child will not be in the same room as my healthcare provider. My healthcare provider has explained to me how the video conferencing technology will be used in connection with this appointment/treatment.
3. I understand that I/my child may benefit from telepsychiatry, but results cannot be guaranteed or assured. The benefits of telemedicine may Include but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.
4. The technology used by Real Hope Real Help, Zoom Video Communications, Inc., is encrypted to prevent unauthorized access. Despite Real Hope Real Help's best efforts to protect the privacy of such Information, security protocols could fail, causing a breach of privacy of confidential and Protected Health Information. Thus, I understand there are potential risks when using this technology, including interruptions, possible unauthorized access of medical information, and technical problems, e.g., equipment failure.

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Informed consent and agreement for Telepsychiatry/Telehealth Services (continued)

5. I understand that I have the right to withhold or withdraw consent to telepsychiatry treatment at any time without affecting my/my child's right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I/my child would otherwise be entitled.
6. I understand that the laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me/my child during my/my child's treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse or neglect; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
7. I understand that this document will become a part of my/my child's medical record.
8. I understand that I have the right to access my/my child's medical information and copies of medical records in accordance with Texas state law.
9. I understand that if I or my child need emergency mental health services, I should contact my local emergency room and/or call 911.
10. Video recordings of the telepsychiatry appointment may not be taken.
11. I understand that billing will be performed by Real Hope Real Help.
12. I have read !his document carefully and understand the risks and benefits of telepsychiatry treatment and have had my questions regarding the technology answered. I hereby consent to participate in telepsychiatry treatment under the terms described herein.

Patient's Name: _____ Date of Birth: _____

_____	_____	_____
Patient/Parent/Guardian Printed name	Patient/Parent/Guardian Signature	Date

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Authorization to Release Medical Records and Protected Health Information

All information must be completed in full to validate this request. Copies of medical records from **Real Hope Real Help** may take up to 15 business days and may incur a $25 charge due at the time of request, except for the transfer to another mental health professional.

Patient Information:

Patient Name: _____ Date of Birth: _____

Phone number: _____

Releasing Records:
Circle One: From / To
Meredith Hake, APRN, PMHNP-BC
Real Hope Real Help
2300 Highland Village Road, Ste. 210
Highland Village, TX 75077
Ph: 972-966-1079 Fax: 972-767-0755

Circle One: From / To
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Information to be covered by this release:

☐ Full Record ☐ Psychiatric Evaluation ☐ Progress Notes ☐ Lab/Test Results
☐ Other: _____

Purpose of release:

_____

I, _____, authorize the above listed entity and its employees to release for inspection and copying the Protected Health Information (PHI) specified above. I understand the records may contain information of a sensitive and confidential nature, including but not limited to mental health, AIDS/HIV test information, and drug or alcohol treatment. I understand that I may revoke this release at any time by notifying **Real Hope Real Help** in writing. I understand the potential for information to be disclosed following authorization is subject to redisclosure by the recipient and is no longer protected by HIPAA.

_____ _____ _____
Printed Name Signature Date