Doctor or therapist: Gary Glass, M.D. **CHILD/ADOLESCENT**

REGISTRATION INFORMATION

Please Print

CONFIDENTIAL

Child: _____ Birthdate: _____ Gender: M F

Your Name: _____ Relationship: _____ Today's Date: _____

Address: _____ City: _____ ST: _____ Zip: _____

Child's Grade: _____ School: _____ SSN: _____

Child lives with: ___ Both parents/1 home ___ Both parents/2 homes ___ 1 parent (specify): _____
___ Other relative: _____ ___ Other arrangement: _____

Do you have the legal right to seek mental health treatment for this child? ___ Yes ___No
If NOT, do you have permission to seek such treatment? ___ Yes ___No

CONTACT PREFERENCES

Phone (H): _____ (W): _____ (C): _____

___OK to leave message	___ OK to leave message	___ OK to leave message
___ with details	___ with details	___ with details
___ call back # only	___ call back # only	___ call back # only
___ NO message	___ NO message	___ NO message

Email: _____(confidentiality cannot be guaranteed for email communication)

Written Communication/Mail:
___ OK to mail to home address ___ OK to mail to work address: _____

Signature: _____ Date: _____

PRIMARY CARE PHYSICIAN Name: _____ Phone: _____

Address: _____ City: _____ ST: _____ Zip: _____

EMERGENCY INFORMATION In case of emergency, please notify: _____

Phone: _____ Relationship to child: _____

INSURANCE FILING Would you like us to file your insurance for you? Yes No

AUTHORIZATION AND RELEASE I hereby authorize the clinician to release all information necessary to secure payment of benefits from my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I fully understand that I am financially responsible for all charges whether or not paid by my insurance company.

_____ _____
Signature of Insured/Guardian Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date Name of Personal Representative/Description of Authority

NOTIFICATON OF CHANGES I understand I am responsible for notifying the office of any change of address, phone number and/or insurance.

_____ _____
Signature of Patient or Personal Representative Date

Client Name: _____

Client Information (cont'd)

PAST AND PRESENT HISTORY

Put an (X) in the box which includes health/illness/condition history for you and your family.

	Good Health	Poor Health	Deceased	Depression	Suicide	Alcohol Abuse	Drug Abuse	Inattention	Psychosis	Severe Anxiety	Panic Attacks	Nervous Breakdown	Hospitalization for Mental Illness	Eating Disorder	Bipolar Disorder	Other
Patient																
Father																
Mother																
Brothers																
Sisters																
Mother's Mother																
Mother's Father																
Father's Mother																
Father's Father																

Client Name: _____

Registration Information (cont'd)

Medical Information:

Brief Medical History:

_____ Seizure Disorders	_____ HIV	_____ Migraines	_____ Developmental Delay
_____ Diabetes	_____ High BP	_____ M.S./M.D.	_____ Head Injury
_____ Heart Condition	_____ TB	_____ Polio	_____ Birth Trauma

_____ Other _____

_____

Current Medications and Dosage	Prescribing Doctor	Reason(s) for their use:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other persons living in the home:

Name	Relationship	How Long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

It there is any other information you would like us to know at this time, please continue on the reverse side and check here _____. Thank you for completing the registration information.

CONFIDENTIAL

NOTICE OF PRIVACY PRACTICES
(The following is a summary. The full text is located in our waiting room.)

We at Austin Psychotherapy Associates are committed to maintaining the confidentiality of your medical information. In most cases, your records will not be released without your written consent (which you can revoke). However, there are a few exceptions. We are permitted to disclose your medical information to other professionals involved in your treatment.

- We are permitted to use and disclose your medical information to your insurance company, if you choose to use them, or as required by worker's compensation law.
- We may disclose your medical information for public health concerns as mandated by federal or state government.
- We are required to report child abuse or neglect.
- We may release information if you are under the custody of law enforcement, or if ordered by the court.

You may request in writing that we restrict how your information is disclosed for treatment, payment or healthcare operations. Although we are not required to restrict this information, we will do so except in emergency situations.

It is our policy not to release information to family members or other individuals without your written consent. You have a right to access your health records with some limitations. (See restrictions in the full text.) You must submit your request in writing to the Privacy Officer.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or with the government. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact Gayle Harkrider, Privacy Officer, at:

4601 Spicewood Springs Rd
Building 4, Suite 200
Austin, TX 78759

PATIENT COPY

This notice is effective November 14, 2006.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

CONFIDENTIAL

CONFIDENTIAL

IMPORTANT NOTICE REGARDING PRESCRIPTIONS

Gary Glass, M.D.

- At the end of each appointment, you will be asked to make a follow-up appointment. There will be a $10.00 fee for prescriptions called in as a result of a missed appointment or failure to make a follow-up appointment within the period required. If that occurs, no more than a month's supply will be called in and you will need to make a follow-up appointment.

- There will be a $10.00 charge for refills called in after hours, or weekends and holidays.

- There will be a $5.00 charge per prescription for all prescriptions written outside an office visit. This includes prescriptions called in because a written prescription was lost, misplaced, or not turned into the pharmacy.

- Patients residing out of town requesting that prescriptions be mailed will need to provide a supply of self-addressed, stamped envelopes. There will be an additional $5.00 charge for mailing prescriptions if stamped envelopes are not supplied.

- CONTROLLED SUBSTANCES (ADD/ADHD) PRESCRIPTIONS: Controlled substance prescriptions are regulated by the Drug Enforcement Agency and the DPS (from whom I must purchase special forms) and thus cannot be called in to the pharmacy. **There is a 21-day expiration on controlled substance prescriptions.** Expired prescriptions of this type must be returned before a replacement will be issued. There will be a $20.00 fee for rewriting a controlled substance prescription.

- If controlled substance prescriptions or medications are expired, lost in the mail, stolen, misplaced, etc., be advised that I cannot re-issue a prescription until the expired prescription is returned or 30 days have lapsed since the prescription was originally written. I cannot write prescriptions early. I cannot pre-sign or post-date prescriptions.

- If your prescription requires a prior authorization from your insurance company, there will be a $5.00 charge. If the insurance company requires a telephone call from Dr. Glass to discuss the necessity of the medication or a letter of necessity, there will be an additional $10.00 charge.

I have read and understand this policy regarding prescriptions.

_____ _____

Patient Signature Date

_____

Patient Name – PLEASE PRINT

_____ _____

Parent or Guardian Signature for a Minor Date

Revised 8/2014

CONFIDENTIAL

PATIENT COPY

IMPORTANT NOTICE REGARDING PRESCRIPTIONS

Gary Glass, M.D.

- At the end of each appointment, you will be asked to make a follow-up appointment. There will be a $10.00 fee for prescriptions called in as a result of a missed appointment or failure to make a follow-up appointment within the period required. If that occurs, no more than a month's supply will be called in and you will need to make a follow-up appointment.

- There will be a $10.00 charge for refills called in after hours, or weekends and holidays.

- There will be a $5.00 charge per prescription for all prescriptions written outside an office visit. This includes prescriptions called in because a written prescription was lost, misplaced, or not turned into the pharmacy.

- Patients residing out of town requesting that prescriptions be mailed will need to provide a supply of self-addressed, stamped envelopes. There will be an additional $5.00 charge for mailing prescriptions if stamped envelopes are not supplied.

- CONTROLLED SUBSTANCES (ADD/ADHD) PRESCRIPTIONS: Controlled substance prescriptions are regulated by the Drug Enforcement Agency and the DPS (from whom I must purchase special forms) and thus cannot be called in to the pharmacy. **There is a 21-day expiration on controlled substance prescriptions.** Expired prescriptions of this type must be returned before a replacement will be issued. There will be a $20.00 fee for rewriting a controlled substance prescription.

- If controlled substance prescriptions or medications are expired, lost in the mail, stolen, misplaced, etc., be advised that I cannot re-issue a prescription until the expired prescription is returned or 30 days have lapsed since the prescription was originally written. I cannot write prescriptions early. I cannot pre-sign or post-date prescriptions.

- If your prescription requires a prior authorization from your insurance company, there will be a $5.00 charge. If the insurance company requires a telephone call from Dr. Glass to discuss the necessity of the medication or a letter of necessity, there will be an additional $10.00 charge.

I have read and understand this policy regarding prescriptions.

_____ _____

Patient Signature Date

PATIENT COPY

_____

Patient Name – PLEASE PRINT

_____ _____

Parent or Guardian Signature for a Minor Date

Revised 8/2014

Prescriptions From Other Providers

Date of Notification	Medication	Prescribing Physician	Reason for Use	Auth. to speak with Dr.

Frequently Used Over the Counter Drugs, Supplements, and Herbal Remedies

Date of Notification	Medication	Frequency of Use	Reason for Use	Auth. to speak with Dr.

Patient Signature: _____ Date: _____

CONFIDENTIAL

PSYCHIATRIST TO PRIMARY CARE PHYSICIAN
CONTACT LETTER

* To: (Primary Care Physician) _____

From: Gary Glass, M.D.
4601 Spicewood Springs Road
Building 4, Suite 200
Austin, Texas 78759
(512) 467-1376; fax (512) 467-8658

* Re: Treatment of (patient's name) _____

The above named patient is currently under my care for:

_____ Evaluation only
_____ Medication management
_____ Other (describe) _____

Patient's Axis I diagnosis is:

_____ Major Depressive Disorder
_____ Bipolar Disorder
_____ Generalized Anxiety Disorder
_____ Substance abuse/dependence (circle one) _____
_____ Other diagnosis _____

The above named patient has been placed on the following medications:

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

Please order/this office has ordered (circle one) the following labs:

_____ CBC
_____ SMAC
_____ Depakote/Lithium/other: _____ level
_____ Serum pregnancy
_____ Liver function
_____ Thyroid profile
_____ Other: _____

I have requested that the patient consult you re: _____

_____

* I do/do not (circle one) give my permission to release this information to the above named physician.

* Signature: _____ Date: _____

Relation to patient _____

CONFIDENTIAL