Sean S. Howell, M.D.
4601 Spicewood Springs Rd.
Bldg. 4, Suite 200
Austin, Texas 78759
512-467-1376

PATIENT SERVICES CONTRACT

Welcome! I look forward to our working together toward your happiness and success. Below are some items that will help us work together:

If you have an emergency, please call 911 or go to the nearest emergency room.

If you have an urgent matter, please call me at 467-1376. I will return calls within 24 hours. **Phone calls or clinical discussions at times outside your appointment are subject to billing as per our office fee schedule.**

We follow up at least every one to two months once you are stable.

Please arrive 10-15 minutes before your appointment to allow time to complete any additional paperwork. To ensure that you receive a thorough, full appointment with Dr. Howell, **we may reschedule any patient who checks in 15 minutes past the scheduled appointment time.** If you anticipate that you will be late or if you choose to cancel your appointment, please call our office ahead of time to let us know.

48 business hours notice is required for cancellations. If we do not receive 48 business hours notice, a fee of $100.00 will be charged. **After three no show events, we may discharge you from Dr. Howell's care.**

Payment is due at the time of service. I accept cash, check, MasterCard or Visa.

Fee Schedule

Initial Neuro-Psychiatric Evaluation (60-75 minutes)	$300.00
Office Visit (50-60 minutes)	$250.00
Office Visit (20-30 minutes) Follow-up	$125.00
Letters, form completion, copying, documents prorated at $250.00/hour	
Phone calls prorated at $250.00/hour	

Dr. Howell does **NOT** complete disability forms. We will comply with forwarding your psychiatric records to the appropriate employer or other bureau. If your case requires this, we will provide you names of potential providers who work with disability issues.

Dr. Howell does **NOT** do forensics/legal work. If your case requires this, we will provide you names of potential forensic psychiatrists. If unavoidable legal issues do arise, Dr. Howell charges the following:

LEGAL MATTERS ARE PAYABLE IN ADVANCE $500.00 PER HOUR
Fee applies to all time spent involving litigation: phone calls/discussions related to legal issues, including but not limited to, legal consultation/representation, expert testimony, documents, travel time and must be **paid in advance.**

Prescriptions
The handwritten prescription that Dr. Howell gives you during your appointment should provide you enough refills to get you through to your next scheduled office visit. If we have to phone in a prescription because you lost it after Dr. Howell has written it and handed it to you, **there will be a $10.00 charge** to re-do the prescription. Since this is a clinical matter and must be discussed with Dr. Howell, **please give two days notice.**

Prescriptions for stimulants are controlled by Federal Law and must be handwritten every 30 days. They must be filled within 7 days or they are invalid. Please leave us self-addressed, stamped envelopes if you do not want to have to pick this prescription up from the office each 30 days. We do not automatically send prescriptions. You must call and give us 48 hours notice. There will be a $10.00 charge to mail your prescriptions to you if you have not provided us with self-addressed, stamped envelopes. **Also, there is a $10.00 per prescription charge each time we write a controlled prescription that is not written during your appointment time.**

If there is a problem with your prescription, please have the pharmacy call, not fax.

I have read, understand and agree to the above.

_____

Signature Print Name Date

Sean S. Howell, M.D.
Psychiatrist
4601 Spicewood Springs Rd.
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Dear New Patient:

It is my policy to require a valid credit or debit card to secure your appointment date and time. Your credit or debit card will not be charged and we will file the claim with your insurance and only your copay will be due at the time of service. If the appointment is not kept or you do not call to cancel the appointment 48 hours prior to the set appointment date and time, then your credit or debit card will be charged the full initial evaluation fee of $300.00

The above policy is to secure your appointment time while assuring me that you will keep your set appointment.

I look forward to meeting and working with you.

Sincerely,

Sean S. Howell, MD

Sean S. Howell, M.D.
Psychiatrist

PATIENT INFORMATION

Patient Name (Please Print) | Marital Status | Date of Birth

S M W D P Sep.

Home Address | City/State | Zip Code | Home Phone # | Cell Phone #

Driver's License # | E-mail address

Patient's Employer | Occupation | How long employed? | Business Phone #

Employer's Address | City/State | Zip Code

In case of emergency, contact (name, relationship and phone number):

Person responsible for billing (if not listed above) | Phone #

Billing Address | City/State | Zip Code

Pharmacy | Phone

Who referred you to this practice? | Primary Care Physician | Phone #

Allergies

Health Conditions

Prescription Medications Currently Taking

Non-Prescription Medications/Herbs

Hospitalizations & Dates

Surgeries & Dates

Past Psychiatric Medications

Relative's Medical Conditions

Relative's Psychiatric Conditions

INSURANCE INFORMATION

Insurance Company Name	Phone Number
Policy Holder Name	Date of Birth
Group #	**Insurance Authorization Number**
Insurance ID #	Insurance Effective Date

Please contact your insurance company to verify your out patient mental health benefits, co-pay amount and obtain your insurance authorization/request ID number if applicable.

Please remember to return your paperwork along with your check 5 days prior to your appointment.

I called my insurance company to verify my out patient mental health benefits on _____.
(date)

My copay per each visit is $_____.

My insurance company issued me the following authorization number _____ .

This insurance authorization number is for _____ number of sessions.

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CONSENT FOR TREATMENT

I give full consent for the completion of an Evaluation/Assessment and the provision of treatment as necessary until I otherwise notify Dr. Sean Howell.

Signature of Patient Printed Name Date

For the treatment of CHILDREN/ADOLESCENTS/DEPENDENTS:

I certify that I have legal responsibility and custody for _____, including the **specific right** to initiate mental health treatment on their behalf. I give full consent for the completion of an Evaluation/Assessment and the provision of treatment as necessary until I otherwise notify Dr. Sean Howell.

Signature of Parent/Guardian Printed Name Date

Consent to Treatment with Psychoactive Medication
Information Sheet

Consumer's Rights Under the Consent to Treatment with Psychoactive Medication Rule

General Information Regarding Rights and Consent

You have the right to decide whether to take this medicine as recommended by your doctor. You can agree to take the medicine; this agreement is called "consent." You have the right not to agree to take this medicine. If you do not agree to take or if you object to taking the medicine, your objection will be recorded in your medical file. You have the right to withdraw your consent to treatment with psychoactive medications at any time.

There may be a person who is authorized to agree or object for you. That person is called your "legally authorized representative." Your "legally authorized representative" can be one of your parents if you are a minor and did not admit yourself or a person appointed by a court to look after your well-being, usually called a guardian. No other person can consent or object for you.

You have the right to know what may happen if you do not choose to take the medicine. If you are under a court ordered temporary or extended commitment, your doctor may petition the court for approval to prescribe and administer psychoactive medication(s) despite your objections. You have the right to be represented by an attorney and to appeal the judge's decision. You should be told whether not taking the medicine might cause the occurrence, increase or reoccurrence of mental illness.

You have the right to be informed about and to discuss with your doctor and other types of treatment your doctor thinks can reduce or control your symptoms and help you feel better. You are entitled to know this before you give your consent or before you make an objection to taking the medicine. You have the right to know how the medicine will be given to you, how frequently and for how long it will be given to you.

You have the right to know that all medicines have side effects; some are mild and some severe. Some side effects may be permanent. You have the right to know this before giving your consent or making your objection to taking the medicine.

You have the right to know what side effects might occur if you take the medicine. You have the right to know which side effects you, as an individual, may likely experience. You have the right to know what kind of permanent problems may occur because of taking this medicine for a long time or in a large amount. Written material which describes the risks and benefits of the medicine will be given to you, and read if necessary, to you or your legally authorized representative before medication is administered to you.

You need to immediately tell your doctor or the staff if you have any problems while taking the medicine. You should always tell your doctor or the staff about any other medicines you are taking or are allergic to.

After these things have been explained to you, you still have the right to object to the medication. However, you may be given appropriate medication without your consent if there is a situation in which it is immediately necessary to give mediation to you to prevent:

1. imminent or probable death or substantial bodily harm to yourself if you:
    a. openly or continually threaten or attempt to commit suicide or serious bodily harm,

or

    b. are behaving in a manner that indicates that your are unable to satisfy your need for nourishment, or essential medical care, or self protection, or there is

2. imminent physical or emotional harm to others because of your threats, attempts, or other acts which are openly or continually made or done.

If your medication and/or group(s) of medicine is to be changed or the way of taking the medicine is to be changed, you again, have the right to be informed of the change. Information should be given to you about any new medicine or any changed in your medication including how it will be give to you (pill, liquid, or injection), how much you will receive at one time, and when you will receive the medication.

Patient Signature Date

Legal Qualified Representative Relationship to Patient Date

Appointment Reminder

You can receive an appointment reminder to your email address, your cell phone (via text message), or you home phone (via a computer generated voice message) the day before your scheduled appointment.

Your name (please print): _____

Where would you like to receive appointment reminders? Check only one.

_____ Your home phone: _____
Via an automated telephone message to my home phone.

_____ Your email address: _____
Via an email message to the address listed above.

_____ Your cell phone number: _____
Via a text message on my cell phone (normal text message rates will apply).

Your cell phone carrier (circle one):

Alltell AT&T Boost Mobile Nextel Sprint SunCom T-Mobile Verizon

VoiceStream Virgin Mobile Cricket US Cellular Metro PCS Qwest

SunCom ACS (Other): _____
Please print cell phone carrier name

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____
Signature Date

Notice of Psychiatrists' Policies and Practices
to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This information is required under the Health Insurance Portability and Accountability act (HIPAA) passed by congress in 1996.

I. Uses and Disclosure for Treatment, payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"

- *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as you family physician or another psychiatrist.

- *Payment* is when I obtain reimbursement for your health care. Example of payment is when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

- *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of [office, clinic, practice group, etc.] Such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosure Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of you medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provided the insurer the right to contest the claim under the policy.

III. Uses and Disclosure with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must take a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, The Texas Youth commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the Texas State Board of Social Worker Examiners, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Psychiatrists' Duties

- **Patient's Rights:**
- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record, I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right o receive an accounting of disclosures of PHI for which you have neither provided consent or authorization (as described in section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychiatrists' Duties

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a written copy by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy right, you may contact me at 467-1376.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to me at 4601 Spicewood Springs Rd., Bldg. 4, Suite 200, Austin, TX 78759.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date of Privacy Policy

Effective on April 14, 2003.

I have received a copy of this document.

_____ _____

Client Signature Date