Northwest Psychiatry

NEW PATIENT BASIC INFORMATION

Please PRINT AND complete ALL sections below

Patient Information			
Patient Name:		Date of Birth:	
Previous Name:		Social Security #:	
Home Phone:		Work Phone:	
Cell Phone:		Email:	
Street:		Apt:	
City:		State:	Zip:

Insurance Information			
Insurance Name:		Member/Subscribe Name:	
Member/Subscriber Date of Birth:		Member/ Subscriber SSN#:	
Member ID Number:		Group Number:	
Insurance Phone Number:			

How did you hear about us? _____

Brief Personal History	
Where were you born?	
Where were you raised?	

Education		
Did you finish high school?	☐ Yes	☐ No
Did you go to college?	☐ Yes	☐ No
Did you finish College	☐ Yes	☐ No
Did you have academic or behavioral problems during any of your school years?	☐ Yes	☐ No

Sexual Orientation

☐ Heterosexual ☐ Gay/ Lesbian ☐ Bisexual

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership

If you have been married before, please describe in detail the number of times you have been married and how long did each marriage last?

Patient Name:	Date:

Employment & School

☐ Full Time	☐ Part Time	☐ Unemployed	☐ Retired
Name of Employer:		Employment Position:	
Currently In School or Training Program?	☐ Yes	☐ No	
Name of School or Training Program?			

Children / Siblings

Do you have Children?	☐ Yes ☐ No
How many?	
What are their ages?	
Do you have siblings?	☐ Yes ☐ No
How many?	

Please list any known *MEDICATION* allergy: _____

Are you taking any prescription medications? ☐ Yes ☐ No
If yes, please fill out the section below. Please feel free to attach a list of all your Rx medicines if space provided below is not sufficient.

Current Prescription Medication

Medicine Name:	Strength/Dose	How often taken	Date Started

Medical History

Arthritis ☐ Yes ☐ No	Asthma ☐ Yes ☐ No	Cancer ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Thyroid Disease ☐ Yes ☐ No	Allergies ☐ Yes ☐ No
Irritable Bowel ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No	Seizures ☐ Yes ☐ No	Anemia ☐ Yes ☐ No	Migraines ☐ Yes ☐ No
GERD ☐ Yes ☐ No	Other:		

Patient Name:	Date:

Please list below all your Physicians including your Primary Care Physician and their contact information.

Current Physicians			
Name of Physician	**Specialty**	**Phone Number**	**Ok to Contact**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Do you currently see a counselor/psychotherapist? ☐ **Yes** ☐ **No**

Therapist			
Name of Therapist	**Specialty**	**Phone Number**	**Ok to Contact**
			☐ Yes ☐ No

Have you been in counseling or psychotherapy before? ☐ Yes ☐ No

Have you seen a Psychiatrist before? ☐ **Yes** ☐ **No**

If yes, please provide the name and contact information of your previous psychiatrist.

Name:	**Phone Number:**

Have you had any psychiatric hospitalizations? ☐ **Yes** ☐ **No**

If yes, please indicate where and approximate dates:

Hospitalizations			
Hospital Name	**Date Admitted**	**Date Discharged**	**Attending Physician**

Patient Name:	Date:

Do you use tobacco? ☐ No ☐ Yes

(If yes, please indicate number of cigarettes/day) _____

If you have quit tobacco, please indicate date quit? _____

Do you consume alcohol? ☐ No ☐ Yes

(If yes, please describe frequency and quantity of alcohol consumption)

_____ (# of glasses) **per** ☐ Day ☐ Week ☐ Year

Illicit Drug Use				
Substance	**Current Use**		**Past Use**	
Cannabis (Marijuana)	☐ Yes ☐ No		☐ Yes ☐ No	
Cocaine	☐ Yes ☐ No		☐ Yes ☐ No	
Ecstasy	☐ Yes ☐ No		☐ Yes ☐ No	
LSD	☐ Yes ☐ No		☐ Yes ☐ No	
Rx Drug Abuse	☐ Yes ☐ No		☐ Yes ☐ No	
Amphetamines	☐ Yes ☐ No		☐ Yes ☐ No	
Heroin	☐ Yes ☐ No		☐ Yes ☐ No	
Other (please specify)				

Have you ever been in detox or rehab ☐ No ☐ Yes

If yes, please list below the name of Facility and approximate dates.

Detox / Rehab			
Facility Name	**Date Admitted**	**Length of Stay**	**Attending Physician**

Do you have any history of childhood abuse? ☐ Yes ☐ No

Is there family history of alcohol/substance abuse? ☐ Yes ☐ No

If yes, please provide further information.

Family History alcohol/substance abuse	Family Member(s)
History of Alcoholism	
History of Illicit Drug use	

Is there family history of psychiatric illness? ☐ Yes ☐ No

Family History Psychiatric Illness	Family Member(s)
Depression	
Anxiety disorder	
Bipolar disorder	
Suicide attempts in family	
Completed Suicides	
Schizophrenia	

Patient Name:_____ Date:_____

Are there any psychiatric medications that you have previously taken? If yes, please check below.

Antidepressants

- ☐Anafranil (Clominpramine)
- ☐Asendin(Amoxpine)
- ☐Celexa (Citalopram)
- ☐Cymbalta (Duloxetine)
- ☐Deplin (L-Methylfolate)
- ☐Trazodone(Desyrel)
- ☐Elavil(Amitryptaline)
- ☐Effexor (XR) (Venlafaxine)
- ☐Fetzima (Levomilnacipran)
- ☐Lexapro(Escitalopram)
- ☐Ludiomil(Maprotiline)
- ☐Marplan(Isocarboxazid)
- ☐Nardil(Pheneline)
- ☐Norpramin(Desipramine)
- ☐Parnate(Tranylcypromine)
- ☐Pamelor or Aventyl(Nortryptaline)
- ☐Paxil(Paroxetine)
- ☐Prozac(Fluoxetine)
- ☐Pristiq(Desvenlafaxine)
- ☐Remeron(Mirtazinpine)
- ☐Serzone(Nefazodone)
- ☐Sinequan(Doxepin)
- ☐Surmontil(Trimipramine)
- ☐Tofranil(Imipramine)
- ☐Trintellix (vortioxetine)
- ☐Vivactil(Protriptylinne)
- ☐Viibryd
- ☐Wellbutrin(SR,XL)(Bupropion)
- ☐Zoloft(Sertraline)
- ☐Luvox (Fluvoxamine)

Anxiolytic/Sedative/Hyponotic

- ☐Ambien (CR) (Zolpidem)
- ☐Ativan(Lorazepam)
- ☐Atarax/Vistaril(Hydroxyzine)
- ☐Bendadryl
- ☐Belsomra (suvorexant)
- ☐Buspar(Buspirone)
- ☐Centrax(Prazepam)
- ☐Cogentin(Benztropine)
- ☐Dalmane(Flurazepam)
- ☐Halcion(Triazolam)
- ☐Inderal(Propranolol)
- ☐Klonopin(Clonazepam)
- ☐Librium(Chlordiazepoxide)
- ☐Noctec (Chloral Hydrate)
- ☐Phengram(Promethazine)
- ☐Restoril(Temazepam)
- ☐Serax(Oxazepam)
- ☐Tranxene(Clorazepam)
- ☐Valium(Diazepam)
- ☐Xanax(Alprazolam)

Antipsychotics

- ☐Abilify(Aripiprazole)
- ☐Clozaril(Clozapine)
- ☐Fanapt(Iloperiddone)
- ☐Geodon(Ziprasidone)
- ☐Haldol(Haloperidol)
- ☐Loxitane(Loxapine)
- ☐Latuda(Lurasidone)
- ☐Mellaril(Thioridazien)
- ☐Moban(Molindone)
- ☐Navane(Thiothixene)
- ☐Orap(Primozine)
- ☐Prolixin(Fluphenazine)
- ☐Rexulti (brexpiprazole)
- ☐Risperdal(Risperidone)
- ☐Saphris (Asenapine)
- ☐Serentil(Mesoridazine)
- ☐Seroquel(Quetiapine)
- ☐Stelazine(Trifluoperazine)
- ☐Thorazine(Chlorpromazine)
- ☐Invega(Paliperidone)
- ☐Trilafon(Perphenazine
- ☐Vraylar (cariprazine)
- ☐Zyprexa(Olanzapine)

Chemical Dependence

- ☐Antabuse(Disulfuram)
- ☐Campral(Acamprosate)
- ☐Revia(Naltrexone)
- ☐Vivitrol (Naltrexone)

Mood Stablizers

- ☐Depakote (Valproic Acid)
- ☐Lithium(Eskalith,Lithobid)
- ☐Lamictal(Lamotrigine)
- ☐Neurontin(Gabapentin)
- ☐Tegretol(Carbamazepine)
- ☐Topamax(Topiramate)
- ☐Trileptal(Oxcarbazepine)
- ☐Lyrica
- ☐Nuedexta (Dextromethorphan / Quinidine)

Stimulants

- ☐Adderall(XR)(Dextroampheamines)
- ☐Catapres(Clonidine)
- ☐Concerta(Methylphenidate)
- ☐Cyclert(Pemoline)
- ☐Dexedrine(Dextroamphetamine)
- ☐Evekeo (amphetamine sulfate)
- ☐Metadate ER/CD(Methlyphenidate)
- ☐Provigil(Modafanil)
- ☐Ritalin(Methlyphenidate)
- ☐Strattera(Atomoxetine)
- ☐Vyvanse(Lisdexamfetamine)

Patient Name:	Date:

NOTICE AND CONSENT

As the patient or their legal representative, I hereby consent to necessary examination, procedures, and/or treatments prescribed by my physician, his/her assistants, or designee as is necessary in his/her judgment.

I authorize my doctor and Northwest Psychiatry PA to use and disclose my personal health information to receive payment for the care I receive. I have received a copy of the Notice of Information Privacy Practices with further details on how my health information may be used.

I agree to be responsible for all charges during my treatment. I have been notified that some services may not be covered under my insurance plan and I am financially responsible for any non-covered services. If the office files a claim to my insurance carrier, I authorize payment of medical benefits to be made to my physician. In the event my insurance carrier does not pay my claim within a reasonable amount of time (60 days) I may be billed for services provided. I have read and acknowledge the receipt of office financial policy.

I understand that if I do not call at least 24 business hours in advance of a scheduled appointment to cancel, arrive 5 or more minutes late for the appointment or if I simply miss (no-show) a scheduled appointment I will be charged a missed appointment fee.

My signature below indicates I have read the Notice and Consent and agree to all terms.

_____ _____/_____/_____

Patient's Signature Date

_____ _____/_____/_____

Signature of Witness Date

Northwest Psychiatry
Arvinder Walia, MD

11673 Jollyville Rd., Bldg. B, Ste. 202
Austin, TX 78759
Tel: (512) 342-7979
Fax: (512) 637-2596

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Information

Patient's Name:		Date of Birth:	
Previous Name:		Social Security #:	

I request and authorize **Northwest Psychiatry** To ☐ **Provide** ☐ **Receive**
My Medical and Mental Health records ☐ **To** ☐ **From**

Healthcare Provider / Entity Information

Name:				Specialty:	
Street:					
City:		State:	Zip Code:	Tel:	Fax:

The Purpose Of Release:

This request and authorization applies to:

☐ **Continuation of Care**	☐ **Transfer of Care**	☐ **Coordination of Care**
☐ **Legal**	☐ **Other: (Please Specify)**	

Information To Be Released:

This request and authorization applies to:

☐ **Entire Record**	☐ **Visit Notes**	☐ **Labs /MRI /X-Ray**
☐ **Dates _____to_____**		

This Consent is subject to revocation at any time, except to the extent that action has been taken in reliance on the patient's consent.

Patient Signature:		Date Signed:	

NOTE TO RECEIVER (Notice Prohibiting Redisclosure): This information has been disclosed to you from records protected by federal confidentiality rules(42 CFR Part2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of rht person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

NORTHWEST PSYCHIATRY PA

PATIENT FINANCIAL POLICY SHEET

Thank you for choosing our practice to handle your behavioral health needs.

We are dedicated to providing you with the best possible care and service. Understanding your financial responsibilities is an essential element to your care and treatment. If you have any questions regarding these policies, please feel free to contact our office staff.

Unless we have the ability to bill your insurance, **full payment is due at the time of service**.
No personal checks are accepted.
For your convenience we accept the following payment types:

- ▪Cash
- ▪Visa
- ▪Discover
- ▪MasterCard
- ▪Money Orders

OFFICE VISIT STANDARD RATES:

- Initial Evaluation: $300.00
- Medication Management (routine follow up): $120.00
- Medication management with psychotherapy: $210.00
- Phone consultations that exceed 5 minutes: $105.00 per 15 min.
  (Phone consultations are **NOT** covered by insurance)
  Rates may vary depending on insurance contracts

Patient Initials: _____

MEDICATION REFILLS:

- Prescription refills for controlled substance (outside of office visit): $12.00
- Prescription refills require a notice of 3 business days.
- Prescription re-write: $15.00

Patient Initials: _____

APPOINTMENTS:

- Courtesy reminder calls are made 1 business day prior to your scheduled appointment. Please be sure to keep our office updated with current contact numbers and mailing address.
- Cancellations made less than 24 business hours prior to your scheduled appointment will result in a missed appointment fee of: $100.00
- Missed appointment fees are **NOT** covered by insurance. The office reserves the right to charge Patients for any and all missed appointments.
- Patients who arrive more than 5 minutes past their scheduled appointment time will not be seen and will need to be rescheduled. Late arrivals may also result in a missed appointment fee: $100.00
- Patients who are consistently unable to keep their scheduled appointments will receive written notification of discontinuation of care, via United States Postal service.

Patient Initials: _____

MISCELLANEOUS FEES:

- **Medical Records:** Pages 1-20: $25.00, $0.50 per additional page, plus postage.
- **Letters:** Minimum of $25.00 charges may vary dependant on nature and complexity of a letter.
- **FMLA:** Requires an appointment, paperwork charges may vary.

Patient Initials: _____

INSURANCE POLICY:

- Our office will only submit claims and accept insurance reimbursements from insurance carriers for which we are contracted with. Patients are responsible for any coinsurance amounts, co-payments, and deductibles as outlined by the individual's insurance carrier. Our office policy is to collect coinsurance, co-payments, and deductibles when you arrive for your appointment.

- If you have insurance coverage with a carrier who we are not contracted with, we may offer to prepare a claim for you on an unassigned basis. This means that it is your responsibility to send your insurance carrier the filled out claim. As a result any reimbursements would be sent directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

- If you are a Medicare beneficiary please notify our office as soon as possible, as we are not a Medicare contracted provider.

- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- It is the Patient's responsibility to inform our office of any changes in insurance coverage at least 48 business hours prior to the scheduled appointment, this is to ensure correct benefit information and any required authorizations. Failure to do so will result in full office visit charges due by the patient at the time of the scheduled appointment.

Patients Initials: _____

By signing below, you acknowledge that you have read and understand the policies as outlined. Further more you give authorization of payment of medical benefits to our office for services rendered. Terms and condition are subject to change.

_____

Print Name of Patient

X_____ _____/_____/_____

Patient Signature Date

Northwest Psychiatry PA

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Northwest Psychiatry PA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Northwest Psychiatry PA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Northwest Psychiatry PA on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____
Patient Name

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Witness Date

Northwest Psychiatry PA

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.

_____

Patient Name

_____

Patient Signature

_____/_____/_____

Date

NORTHWEST PSYCHIATRY PA

POLICY REGARDING CONTROLLED SUBSTANCES

Controlled substance medications are very useful but have a high potential for misuse and are closely regulated by both state and federal governments. Examples of controlled substances include, most prescription medications, (Ambien, Lunesta, etc.), anxiety medications (Klonopin, Xanax, Ativan, Valium, etc) and stimulants, (Provigil, Adderall, Ritalin, etc.) For this reason we require all patients who are prescribed controlled substances from Northwest Psychiatry to be seen every 90 days. Refills will not be provided beyond this time period.

- Medications will **NOT** be replaced if they are misplaced or destroyed. If your medications have been stolen and you bring in an official police report regarding the theft, an exception could be made at the discretion of the provider.

- We recommend all controlled substance prescriptions are continuously filled at the same pharmacy each month. In the event of a pharmacy change, please notify our office as soon as possible. Failure to notify the office of pharmacy changes could result in termination from the practice.

- In the event the provider or patient will be out of town at the time a refill is due, a prescription may be issued to the patient prior to the scheduled refill date. However, the prescription will contain specific instructions for the pharmacist regarding when the prescription is allowed to be filled. Refills are to be requested through your pharmacy. Provider requires one business day to complete all refill requests. Timely requests for medication refills are solely the patient's responsibility.

- Schedule II medications require a written prescription and cannot be called or faxed to your pharmacy. Patients must call our office three days prior to the Schedule II prescription being written. The patient may either come by the office to pick up the prescription when it is ready, or the prescription may be mailed. It is the patient's responsibility to ensure that Northwest Psychiatry possesses the patient's correct mailing address. Prescriptions that are lost in the mail will NOT be rewritten under any circumstances. Patients will be **REQUIRED** to get random urine drug and toxicology screens as a part of their treatment plan.

- The medications prescribed must be used at a rate no greater than the prescribed rate unless it is discussed directly with the provider. Early refill requests will **NOT** be granted. The patient is responsible for using the prescriptions as prescribed. No unauthorized increase in medications will be allowed. Failure to adhere to this policy may result in termination from the practice.

- Changes in prescriptions/refills will be made only during scheduled appointments and not via phone.

_____

Print Name

_____ _____/_____/_____

Signature **Dated**

NOTICE OF PRIVACY PRACTICES

ARVINDER WALIA, MD
Board Certified in Psychiatry, ABPN
11673 Jollyville Road
Building B, Suite 202
Austin, TX 78759

Tel: (512) 342-7979
Fax: (512) 637-2596

Office Hours: Monday-Thursday 9am – 5pm
Friday 9am – 4pm

Thank you for choosing our office to handle your behavioral health needs.

If you're an established patient and need emergency assistance for your behavioral health needs outside of the office hours please call Medlink at 512-323-5465, Dr. Walia or the physician on call will be paged.

For our office fees please review the patient financial policy provided to you.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. 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. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition in order for he/she to appropriately treat you for any other medical conditions.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we

may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law. For further information on "health care operations" see the definition in the regulation at 45 CFR §164.501.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

We are obligated to responsibly report situations in which patients themselves or others are imminently endangered. Some examples of exceptions to confidentiality include circumstances:

- **Where suicidal or homicidal action if imminent.**
- **Where there is abuse or neglect of elderly or disabled.**
- **Where your insurance company requests information.**

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Texas law requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;

- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a

charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. 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 the government.

F. 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.

G. 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:

Casandra Ruiz
Practice Manager

ARVINDER WALIA, MD
Board Certified in Psychiatry, ABPN
11673 Jollyville Road
Building B, Suite 202
Austin, TX. 78759

This notice is effective: 11/15/06.

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 Patient or Personal Representative

_____
Description of Personal Representative's Authority

Telemedicine Informed Consent

Northwest Psychiatry

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting **Northwest Psychiatry** at **512-342-7979**
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____

Witness Signature Date