NEW PATIENT INFORMATION RECORD

PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____ Sex: Male ( ) Female ( )

Street Address: _____

City/State/Zip Code: _____ Social Security # _____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated

Age: _____ Date of Birth: _____ Drug Allergies: _____

Email: _____ Primary Care Provider: _____

Pharmacy: _____ Phone #_____

Who referred you to Dr. Guerrero? _____ Appointment Reminder: Email ( ) Text ( ) Call ( )

EMERGENCY CONTACT INFORMATION

Contact's Name: _____ Contact's Phone: _____

Relationship to Patient: _____Contact's Address: _____

PERSON RESPONSIBLE FOR PAYMENT (If Different From Above)

Name:_____ DOB: _____ Relationship to Patient:_____

Street Address: _____

City/State/Zip Code: _____ Phone: _____

INFORMATION IF PATIENT IS A MINOR OR STUDENT

Guardian's Name: _____ DOB:_____

Guardian's Street Address: _____

Guardian's City/State/Zip Code: _____

Guardian's Phone: (Home) _____ (Work) _____ (Mobile) _____

Patient's Grade: _____ School: _____

ADDITIONAL INFORMATION

Therapist's Name: _____

Therapist's Address & Phone Number: _____

Primary Reason for Visit: _____

Please remember that payment is expected when services are rendered. The patient is responsible for all charges resulting from professional services regardless of insurance coverage. We are happy, however, to provide you with a comprehensive receipt that you can submit directly to your insurance company for reimbursement.

Patient or Guardian's Signature: _____ Date: _____

Rafael D. Guerrero, M.D.

1830 Snake River Road, Ste. B and E

Katy, Texas 77449

Ph: (281) 398-9800 Fax: (281) 398-9823

OFFICE POLICY

To My Patients

I would like to take this opportunity to thank you for your confidence in choosing me for professional services. Since our goal is to provide you with the best service possible, and in order to serve you more effectively, we ask that you **please read the policy before you sign it.**

Office Hours

Monday, Tuesday, Wednesday and Thursday 8 am – 5 pm Friday 8 am – 1 pm

Appointments

Dr. Guerrero cares about your time. We schedule only one patient per appointment time and never double book. There is typically a wait list of patients that need to see the doctor. For this reason we require a 48 hour notice if you need to cancel or reschedule. This allows us to offer an open appointment to a waiting patient.

As a courtesy, our office calls each patient to remind and confirm of upcoming appointments**. If we leave a message we ask that you please be sure to call back to confirm or reschedule.** If you do not call back to confirm your new patient appointment, your appointment will be cancelled and your credit card in file will be charged for the missed appointment time. If you need to call after hours you can leave a message.

Please Read and Initial

If you schedule a new patient appointment and find that you are unable to come in, please call the office at least 48 business hours in advance so that Dr. Guerrero can use his time most effectively. **Otherwise, you will be charged the full amount of the missed appointment time.** As a courtesy, we will call you one or two days before your scheduled appointment to remind you of the appointment, but it is your responsibility to remember the appointment.

_____ **(INITIAL)**

Initial evaluation lasts **60** minutes. Follow up visits and medication management checks last **30** minutes.

Payment is expected when services are rendered. The patient is responsible for all charges resulting from professional services regardless of insurance coverage.

We accept cash, checks and credit/debit cards (Visa and MasterCard only). The initial evaluation fee is $340.00. Follow up visits and medication management checks are $160.00

Communications

If you need to communicate with the doctor please call the office and the staff will convey your message. Messages are read and attended to by the doctor typically the same day at the end of the clinic day. If you chose to communicate via e-mail please remember that e-mail has the privacy of a post card. E-mail does not go directly from one computer to another and the message can be stored as an archive at any point during delivery. Before you send an e-mail, be cautious with your disclosing. E-mail cannot be a means of managing a crisis, since **one cannot be aware of e-mail arrival at all times.** If you do send an e-mail please call the office and make us aware of it. If you are having an emergency after hours please call us directly at 713-899-7100 (this is not a refill request line).

Our office e-mail address is RGuerreroMD@sbcglobal.net

Additional Fees

There will be a charge of $150 for any reports that are prepared. This fee covers the time spent gathering and reviewing of all records, reports, tests and other accumulated data, and the preparation of the report. This includes reports prepared for school districts as well as completion of guardianship paperwork.

Misc. letters vary from $25-$150 depending on time spent and amount of information gathered.

Conners Performance Tests $85

Psychometric Measurement testing $45 for 1st and $35 for additional tests

A fee of $10 will be charged for replacing lost or expired prescriptions.

Monthly controlled substance prescriptions are written at no charge.

Copying/forwarding of medical records/paperwork will incur a minimum of $25 fee. If paperwork is more than 20 pages, additional charges will apply (0.50 cents for each additional page along with the cost of delivery of records.)

Medication Refills

If you need a refill for a non-controlled medication, please call your pharmacy. If you are out of refills, the pharmacy will contact us for approval.

If you need a prescription for controlled substance medication, please call the office at least **72 hours** before you are going to run out.

Waivers, Authorizations and Notice of Privacy Practices

____ I have received the Notices of Privacy Practices and I have been provided an opportunity to review it.

____ I understand that Dr. Guerrero does not accept insurance and I elect to make payment in full at the time of service.

____ I authorize Dr. Rafael D. Guerrero to provide psychiatric evaluation and treatment for myself and/or my minor child.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICIES

Patient or Guardian's Signature: _____

Printed Name: _____ Date: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

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.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____

Patient's DOB: _____

Signature: _____
Patient or Parent/Legal Guardian

Parent/Legal Guardian Printed Name: _____

Date: _____

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AUTHORIZATION FOR PSYCHIATRIC EVALUATION AND TREATMENT

I, _____ (Patient or Parent/Legal Guardian), hereby authorize Dr. Rafael D. Guerrero to provide psychiatric evaluation and treatment for myself and/or my minor child, _____ (Name of Minor Child).

Patient Name: _____

Patient's DOB: _____

Signature: _____
Patient or Parent/Legal Guardian

Parent/Legal Guardian Printed Name: _____

Date: _____

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DISCLOSURE OF INFORMATION

_____YES I, _____ (Patient or Parent/Legal Guardian), authorize Dr. Rafael D. Guerrero to discuss my case file or my treatment plan and/or my minor child's case file and/or treatment plan, _____ (Name of Minor Child) regarding present treatment course with the following people and **only the following people**. If there should be any additions to this list, I will need to sign an additional authorization form. The persons to disclosure the information to are as follows:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name of School: _____

Name of Therapist/Counselor: _____

Name of Primary Care Physician: _____

OR

_____**NO I, _____ (Patient or Parent/Legal Guardian), DO NOT AUTHORIZE Dr. Rafael D. Guerrero to discuss my case file or my treatment plan with anybody.**

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date

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INSURANCE WAIVER

I, _____, have been informed that Dr. Rafael D. Guerrero does not accept insurance at his Katy office. I elect to use my out-of-network benefits and file a claim for reimbursement for myself or my dependant.

Katy Office: 1830 Snake River Road,
Suite B and E
Katy, TX 77449

I agree to pay in full for all services provided at his out-of-network location.

Signed: _____
(Member/Insured)

Printed Name: _____

Date: _____

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MEDICATION HISTORY

Today's Date: _____

Patient's Name: _____ DOB: _____

Please **list all medications** you have **taken in the past**

or medications that you are **currently taking**:

MEDICATION	DOSAGE	LENGTH OF TREATMENT	POSITIVE EFFECTS	NEGATIVE EFFECTS

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Contract for Controlled Substance Prescriptions

Controlled substance medications (i.e., benzodiazepines, Suboxone, and stimulants.) are very useful, but have potential for misuse; therefore, they are controlled by local, state, and federal governments. They are intended to improve function and/or ability to work, not simply to feel good. Because my provider is prescribing such medications for me to help manage my condition, I agree to the following conditions:

1. **I am responsible for my controlled substance medications.** If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced**. (PATIENT/LEGAL GUARDIAN INITIALS _____)**

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving controlled substances from Dr. Rafael Guerrero. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted to a hospital. **(PATIENT/LEGAL GUARDIAN INITIALS _____)**

3. Refills of controlled substance medication:
a. **Will not be made if I "run out early,"** I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
b. **Will not be made as an "emergency,"** such as a Thursday afternoon because I suddenly realize that I will run out tomorrow and the office will be closed I will call **at least seventy-two (72) hours** in advance if I need assistance with a controlled medication prescription.
c. No Controlled Medications will be ordered when the office is closed. **(PATIENT/LEGAL GUARDIAN INITIALS_____)**

4. I understand the importance of following my treatment plan as directed by my physician/provider and agree:
a. To keep my appointments (including follow-ups and any referrals)
b. To permit urine drug screening without prior notice. **(PATIENT/LEGAL GUARDIAN INITIALS _____)**

5. I understand that if I **violate any of the above conditions,** my controlled substance prescription and/or treatment with Dr. Rafael Guerrero, I may be terminated immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to other healthcare providers, medical facilities, pharmacies, and other authorities. **(PATIENT/LEGAL GUARDIAN INITIALS _____)**

6. I understand that the **main treatment goal is to improve my ability to function and/or work.** In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by the following better health habits: non-use of "street drugs" I understand that using "street drugs" will impact my progress and counter act with any prescribed medications. They are not only mind altering, but also illegal. Continued use after warning can be cause for your care to be terminated immediately from Dr. Rafael Guerrero's care and may be reported to the authorities. **(PATIENT/LEGAL GUARDIAN INITIALS _____)**

I have read this contract and fully understand its content. In addition, I fully understand the consequences of violating this contract.

PRINTED Patient Name:_____

Patient/Legal Guardian Signature: _____Date:_____

Witness Signature: _____Date:_____

Office Use Only:
Copy given to patient _____
Patient declined copy