**Rafael D. Guerrero, M.D.**
*1830 Snake River Road, Ste. B and E*
*Katy, Texas 77449*
*Ph: (281) 398-9800 Fax: (281) 398-9823*

# PATIENT INFORMATION RECORD

## PATIENT INFORMATION

Patient's Name: _____ Preferred Name: _____

Gender: ( ) Male ( ) Female Gender Identity: _____

Age: _____ Date of Birth: _____ Drug Allergies: ( )No ( )Yes_____

Street Address: _____

City/State/Zip Code: _____ Copy of Driver's License ( )

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

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

Email: _____ Primary Care Provider: _____

Pharmacy: _____ Pharmacy phone #: _____

Who referred you to Dr. Guerrero? _____

## EMERGENCY CONTACT INFORMATION

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

Relationship to Patient: _____Contact's Address: _____

## 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) _____ (Mobile) _____ (Work) __ _____

## SIGNATURES (handwritten signature required)

**Patient/Guardian's Signature** (please sign by hand): _____

Printed Name: _____ Date: _____

(Please attach a copy of your Driver's License)

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# 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 - Thursday 8 am – 5 pm Friday 8 am – 1 pm

## Appointments and Cancellation Policy

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. 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.**

Please Read and Initial:

_____ For changing or canceling **NEW PATIENT APPOINTMENTS** please call the office at least **48 BUSINESS HOURS** in advance, otherwise you will be charged the full amount of the missed appointment time.

_____ For changing or cancelling **FOLLOW-UP APPOINTMENTS** please call the office at least **24 BUSINESS HOURS** in advance, otherwise you will be charged the full amount of the missed appointment time.

_____ In case of late cancellations, missed scheduled appointments/virtual consultations, bank returned checks, your credit card will be charged. By initialing, I am authorizing Rafael D. Guerrero, MD, dba Psychiatric Consultants of Houston to charge my credit card according to the guidelines outlined above.

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.

The **initial evaluation is $375.00.** It lasts approximately **60** minutes, and it is billed at the time of scheduling the new patient appointment. The **follow up and medication management visit is $187.00.** It lasts approximately **30** minutes, and it is charged in the morning of the day of your appointment. Patients are responsible for all charges resulting from professional services regardless of insurance coverage. **Current patients that have not had an appointment with Dr. Guerrero for 1 year or more are seen as a Returning New Patient. The Returning New Patient fee is $375.00.** We accept cash, checks and credit/debit cards (Visa and MasterCard only).

## 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 or the following day. **E-mail cannot be a means of managing a crisis, since one cannot be aware of e-mail arrival at all times.**

## 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.

Miscellaneous letters vary from $35-$150 depending on time spent and amount of information gathered.

Cognitive/Performance testing starts at $175.

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 48 hours** before you are going to run out.

## Waivers, Authorizations and Notice of Privacy Practices

_____ (INITIAL) I have received the Notices of Privacy Practices (see HIPAA notice attached below) and I have been provided an opportunity to review it. 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.

_____ (INITIAL) I understand that Dr. Guerrero does not accept insurance and I elect to make payment in full at the time of service. I understand my financial obligations for treatment received from Dr. Guerrero and agree to pay for any and all services provided.

_____ (INITIAL) I understand that Dr. Guerrero does not specialize in the treatment of substance abuse such as alcohol or recreational drug abuse and that I would have to seek the help of another professional or a dual diagnosis program.

_____ (INITIAL) I authorize Dr. Guerrero to provide psychiatric evaluation, and pharmacological treatment for myself and/or my minor child _____ (Name of Minor Child). I am aware that the practice of medicine is not an exact science and of the likelihood of the illness or problems improving or not improving with and without medication. I am aware that Dr. Guerrero will discuss with me any effective alternative treatment available to address the illness, that any possible side effects will be fully explained to me and that I should notify him or the office staff as soon as possible of any side effects. I understand that I may withdraw this consent at any time.

_____ (INITIAL) I understand that at times medications are used to address psychiatric symptoms which have not been specifically approved by the FDA for this use (Off Label Use), that I will be given specific information explaining the risks and benefits of this use and that I will be given the opportunity to ask questions about Off Label Use.

_____ (INITIAL) I understand that if a medication classified as a neuroleptic has been prescribed by Dr. Guerrero, it may produce some persistent involuntary movements of the face and mouth and at times similar movement of the hands and feet. In some instances, these symptoms may be irreversible and may appear after the medication has been stopped. This side effect is usually associated with taking medication for more than three months and can be minimized by lowering the dosage and minimizing the use of other medications. I am aware that I will have an opportunity to discuss this in detail with Dr. Guerrero and that periodic examinations will be conducted to see if such involuntary movements have or do develop.

## HIPAA Notice of Privacy Practices

This notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your protected health information; give you this notice of our legal duties and privacy practices with respect to your protected health information; and follow the terms of our notice that are currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at the time as well as any information we receive in the future. You can obtain any revised Notice of Privacy Practices by contacting our office.

***How We May Use and Disclose Your Protected Health Information.*** The following examples describe different ways that we may use and disclose your protected health information. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office. We are permitted to use and disclose your protected health information for the following purposes. However, our office may never have reason to make some of these disclosures.

*For Treatment*. We will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and any related services. We may also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

*For Payment*. Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to your health plan to obtain approval for hospital admission.

*For Health Care Operations*. We may use and disclose your protected health information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use your protected health information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this notice also may share information with each other for purposes of our joint health care operations.

*Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services*. We may use and disclose your protected health information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

*Fundraising Activities*. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our office and request that these fundraising materials not be sent to you.

*Plan Sponsors*. If your coverage is through an employer sponsored group health plan, we may share protected health information with your plan sponsor.

*Facility Directories*. Unless you object, we may use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

*Others Involved in Your Healthcare*. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

*Required by Law*. We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

*Public Health*. We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

*Business Associates*. We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

*Communicable Diseases*. We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

*Health Oversight*. We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

*Abuse or Neglect*. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

*Food and Drug Administration*. We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required by law.

*Legal Proceedings*. We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
*Law Enforcement*. We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.
*Coroners, Funeral Directors, and Organ Donation*. We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.
*Research*. We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
*Criminal Activity*. Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
*Military Activity and National Security*. When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
*Workers' Compensation*. Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.
*Inmates*. We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.
*For Data Breach Notification Purposes*. We may use or disclose your protected health information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan, if applicable, through which you receive coverage.
*Required Uses and Disclosures*. Under the law, we must make disclosures to you and when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.
***Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information.*** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.
***Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization.*** Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. Additionally, if a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, it is our intent to meet the requirements of the more stringent law.
***Your Rights Regarding Health Information About You.*** The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.
*You have the right to inspect and copy your protected health information*. This means you may inspect and obtain a copy of your protected health information that is contained in your designated file for as long as we maintain the protected health information. A "designated file" contains medical and billing records and any other records that your physician and the office uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must make a written request to inspect and copy your designated file. We may charge a reasonable fee for any copies.
Additionally, if we maintain an electronic health record of your designated file, you have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.
Depending on the circumstances, we may deny your request to inspect and/or copy your protected health information. A decision to deny access may be reviewable. Please contact our office if you have questions about access to your medical record.
*You have the right to request a restriction of your protected health information*. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

This office is not required to agree to a restriction unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you paid us out-of-pocket in full. If this office believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. If this office does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by contacting our office.

*You have the right to restrict information given to your third-party payer if you fully pay for the services out of your pocket*. If you pay in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third-party payer since no claim is being made against the third party payer.

*You have the right to request to receive confidential communications from us by alternative means or at an alternative location*. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office.

*You may have the right to have your physician amend your protected health information*. This means you may request an amendment of protected health information about you in your designated file for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office if you have questions about amending your medical record. Your request must be in writing and provide the reasons for the requested amendment.

*You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information*. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions, and limitations. Additionally, limitations are different for electronic health records.

*You have the right to obtain a paper copy of this notice from us*, upon request, even if you have agreed to accept this notice electronically.

*You have the right to receive notice of a security breach*. We are required to notify you if your protected health information has been breached. The notification will occur by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your protected health information. The notice will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

***Complaints or Questions.*** You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a written complaint with us by notifying our office of your complaint. We will not retaliate against you for filing a complaint. Complaints should be directed to our office located at 1830 Snake River Rd. Suite B and E, Katy, TX 77449, Phone: 281-398-9800, Fax: 281-398-9823. If you have a question about this privacy notice, please contact our Privacy Officer at: 281-398-9800.

If you are not satisfied with the way this office handles a complaint, you may submit a formal complaint to you may complain to the U.S. Department of Health and Human Services, Office for Civil Rights, located at: 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201.

## I HAVE READ AND FULLY UNDERSTAND THE ABOVE POLICIES and I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Patient/Guardian's Signature (please sign by hand): _____

Printed Name: _____ Date: _____

**Rafael D. Guerrero, M.D.**
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*Katy, Texas 77449*
*Ph: (281) 398-9800 Fax: (281) 398-9823*

# 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: _____Phone: _____

Name of Primary Care Physician: _____Phone: _____

_____ _____
Patient/Guardian Signature (please sign by hand) Date

_____ _____
Witness Date

**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 (please sign by hand) Date

_____ _____
Witness Date

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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 medications:**
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 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, 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 (please sign by hand): _____ Date: _____

Witness Signature: _____Date: _____

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

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# TELEPSYCHIATRY

**Dear Patient,**

With telepsychiatry we are now able to offer you psychiatric services using interactive video conferencing tools that are secure and HIPAA compliant. These services allow you to receive psychiatric care without being in the same physical location as Dr. Guerrero.

We will be using Zoom for these video conferences. Zoom's security architecture provides encryption and meeting access controls so data in transit cannot be intercepted, which ensures patient confidentiality.

**Potential barriers/risks to Telepsychiatry:**

- Information transmitted may not be sufficient (*e.g.*, poor resolution of video) to allow for appropriate medical decision-making by my psychiatrist.
- Delays in psychiatric evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- In rare cases, a lack of access to all the information that might be available in a face-to-face visit, but not in a Telepsychiatry session, could result in the omission of care involving other health problems or possible adverse drug interactions.

If you decide that the benefits outweigh the risks, you may request telepsychiatry sessions when you schedule appointments. If Dr. Guerrero agrees, you will be scheduled for a Telepsychiatry session.

Please note that Dr. Guerrero will send you the video conference link right at the time of your appointment, not in advance **(we do not use virtual waiting rooms for video conference appointments)**. If Dr. Guerrero is running behind and sends you the link a few minutes into your appointment time, rest assured that he will make up for any lost time.

**Your Rights**:

- All laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry.
- All the Texas rules and regulations which apply to psychiatry also apply to telepsychiatry.
- You have the right to withhold or withdraw your consent for the use of telepsychiatry at any time during the course of your care, and withdrawal of your consent will not affect any future care or treatment from Dr. Guerrero.
- Dr. Guerrero has the right to withhold or withdraw his consent for the use of telepsychiatry at any time during the course of your care.

**Your Responsibilities:** (Please initial as acknowledgement of understanding)

____ I understand that I must be physically within Texas (including offshore State waters) to be eligible for telepsychiatry, and that Dr. Guerrero can send prescriptions for medications only to Texas pharmacies or addresses. I will inform Dr. Guerrero as soon as my session begins of my physical location.

____ I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because the computer, tablet, or mobile telephone I use must have working camera and audio input so that Dr. Guerrero can see and hear me in real time.

____ I will not record any telepsychiatry sessions without written consent from Dr. Guerrero, and I understand that Dr. Guerrero will not record any of our telepsychiatry sessions without my written consent.

____ I will inform Dr. Guerrero as soon as my session begins if any other person can hear or see any part of our session.

____ If I lose my connection during a session, I will immediately attempt to reconnect.

____ If the audio I am receiving during a telepsychiatry session is not complete and clear, I will attempt to let Dr. Guerrero know or telephone Dr. Guerrero's office at 281-398-9800.

____ I will ensure that I have a valid credit card on file and understand that my card will be charged one to two business days prior to my telepsychiatry appointment.

____ I understand that the rates for Telepsychiatry and In-Person appointments are the same and that the cancellation policy applies equally for both Telepsychiatry and In-Person appointments.

**Patient Consent to the Use of Telepsychiatry:** I have read and understand the information provided above regarding Telepsychiatry. I hereby give my informed consent for the use of Telepsychiatry in my medical care and authorize Dr. Guerrero to use telepsychiatry in the course of my diagnosis and treatment. I agree to hold Dr. Guerrero's and his practice harmless from injuries or omissions that may be related to the malfunction or technical failure of equipment or system encryption.

Patient/Guardian's Signature (please sign by hand): _____

Printed Name: _____ 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*

# MEDICATION HISTORY

Today's Date: _____

Patient's Name: _____ DOB: _____

Please **list all medications** you have **taken in the past** or you are **currently taking**

**OR**

( ) I **have not taken** any prescribed medications in the past or present

| MEDICATION | DOSAGE | LENGTH OF TREATMENT | POSITIVE EFFECTS | NEGATIVE EFFECTS |
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