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 $375.00. Follow up visits and medication management checks are $170.00**

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.

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. 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.

Miscellaneous 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

______ (INITIAL) I have received the Notices of Privacy Practices 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.

_______ (INITIAL) I authorize Dr. Guerrero to provide psychiatric evaluation and treatment for myself and/or my minor child.

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 or Guardian's Signature: ____

Printed Name: ____ Date: ____________________

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CANCELLATION POLICY

Dear Patient,

At our office, we believe that we can provide optimal care only if we have enough time set aside to adequately examine your needs and discuss your condition and treatment options in detail with you. We also value your time and appreciate that a long wait in a doctor's office costs you or your family valuable time. That is why it is our policy to schedule only one patient per appointment time and never double book. Your appointment time is reserved exclusively for you.

_____ (Initials) 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.

_____ (Initials) 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.

This policy ensures that Dr. Guerrero can use his time most effectively and that we might schedule another patient who is on our waiting list for an appointment.

Failure to give timely notice will result in charges for the scheduled appointment time.

I have read and understand the appointment change/cancellation office policy.

Patient or Guardian's Signature: ____

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

Printed Name: ___________________________________Date: __________________

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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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: _______________

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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MEDICATION HISTORY

Today's Date: ________________________________

Patient's Name: ________________________________ DOB: ________________________

Please **list all medications** you have **taken in the past** or you are **currently taking** for the reason of your visit:

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 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: ____________________________________ 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 or Guardian's Signature: ______________________________________

Printed Name: _______________________________ Date: _______________