PATIENT INFORMATION AND MEDICAL HISTORY FORM

ATPY

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security Number: _____

CONTACT

Home: _____ Work: _____ Cell: _____

May we leave a detailed message? YES NO IF YES, please circle the preferred number.

Email: _____

May we email you for appointment reminder, confidential results, promos, etc? YES NO

Circle preferred appointment reminder: Email Text Message Phone[h] Phone[w] Phone[c]

ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

EMPLOYMENT

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to Patient: _____

GUARANTOR (IF UNDER 18)

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to Patient: _____

Address: _____

FINANCIALLY RESPONSIBLE PARTY

Subscriber Last Name: _____ Subscriber First Name: _____

Insurance Type: _____

Member ID Number: _____ Group Number: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Address: _____ Phone #: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Address: _____

Phone: _____ Fax: _____

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
E. Marie Hall Institute *for*
Rural *and* Community Health

Patient Name:
DOB:
Medical/TDCJ #:
Provider Name:
Telemedicine site:

Informed Consent to Telemedicine/Telepharmacy Consultation

I have been asked by my healthcare provider to take part in a telemedicine/telepharmacy consultation with Texas Tech University Health Sciences Center (TTUHSC) and its physicians, associates, technical assistants, pharmacists, affiliated hospitals and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine/telepharmacy consult is done through a two-way video link-up whereby the physician or other health provider at TTUHSC can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The TTUHSC and affiliated telemedicine/telepharmacy consultants can not be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. I know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

    If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
8. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
9. I will not receive any royalties or other compensation for taking part in this telemedicine/telepharmacy consult or associated with any use by TTUHSC.
10. I understand I can make a complaint of my provider to the Texas Medical Board by going online at http://www.tmb.state.tx.us/page/place-a-complaint or calling the Complaint Hotline at 800-201-9353.

I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as "agree" and I do not agree to any that I have initialed as "decline."

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize TTUHSC and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____ **Time:**_____ **am/pm**

Signature:_____ **Printed Name:**_____

Witness: _____ **Interpreter (if applicable):**_____

Texas Tech University Health Sciences Center Ambulatory Clinics Consent to Treatment/Health Care Agreement	Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment, identification and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I understand that my prescriptions and prescription history will be sent, received and shared electronically with other healthcare providers and pharmacies. In addition, my medical records are available to other healthcare providers for treatment purposes through Health Information Exchanges (HIE). An HIE is an electronic system that stores your health information from multiple sources, not just TTUHSC, and may contain mental health and substance abuse information. Providers will attempt to exclude certain mental health and substance abuse records, but some portions of this information may be included. I may opt out of the HIE by completing an Opt-Out form. If I later change my mind, I may opt back in the same way.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct. **I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.**

ADVANCE DIRECTIVE:

Do you have a current, signed Advance Directive? ____YES ____NO
Has a signed copy been provided to TTUHSC? ____YES ____NO

By signing below, I agree I have read this form or it has been read to me and I understand what it is saying and agree to the terms.

Date **Print Name** **Signature Patient/ legally authorized person**

Witness/Translator **Relationship to Patient**

Revised January 2020
6.21.B

Informed Consent to Telemedicine/Telephone/Telepharmacy/Teletherapy Consultation

You are scheduled for a telemedicine/telephone/telepharmacy/teletherapy consultation. Prior to your visit, is important that you read and understand this document.

By signing this document, you are attesting that you understand:

1. The purpose is to assess and treat your medical condition.
2. This consult is done through a two-way communication whereby the physician or other health provider at TTUHSC can see your image on the screen and/or hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touchor smell; and it may not be equal to a face-to-face visit.
3. Since we are in different locations, we must rely on information provided by you. TTUHSC and affiliated telemedicine/telephone/telepharmacy/teletherapy consultants rely on your accurate and complete information to provide appropriate care.
4. You can ask questions and seek clarification of the procedures and telemedicine technology.
5. You can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. You know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

    If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed, heard or videotaped by medical and non-medical persons for evaluation, informational, research, educational, quality, technical purposes, or as might be required by my health coverage plan.
8. You understand you can make a complaint of your provider to the appropriate licensing board.

If you have any questions or concerns about this document, please make sure to ask your nurse or healthcare provider.

Printed Name: _____

Signature: _____

Date: _____

Revised March 17, 2020

Texas Tech University Health Sciences Center

Confidential Communication Request

Patient Name _____

MRN _____

DOB _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

☐ Permission to give verbal protected health information (including appointment information) and leave messages with the following person(s): Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: _____ Relationship _____ Phone # _____

Name: _____ Relationship _____ Phone # _____

Name: _____ Relationship _____ Phone #: _____

Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.

Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? _____
2. What town were you born in? _____
3. What is your grandmother's name? _____
4. What is the name of your first pet? _____

Date _____

Print Your Name and Relationship to Patient (Person signing consent form) _____

Signature (Patient or Other Legally Authorized Person) _____

Relationship to Patient _____

Texas Tech University Health Sciences Center **Acknowledgement of Notice of Privacy Practice and Confirmation of Various Healthcare Communications**	Patient Name: _____ MRN: _____ DOB: _____

☐ I have received a copy of the Texas Tech University Health Sciences Center (TTUHSC) Notice of Privacy Practices (rev. 3/16) in accordance with 45 CFR § 164.520.

Consent to Email or Text Usage for Appointment Reminders and other Healthcare Communications:

☐ I consent to receive email and/or text messaging from TTUHSC to remind me of an appointment, for surveys about my experience with the healthcare team, or to provide general health reminders or information about new services.

The cell phone number and/or email I authorize for TTUHSC to use are listed below:

Email: _____

Cell phone number: _____

TTUHSC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

By signing below, I acknowledge any options selected above, will remain in effect until further written notification by me.

Date	Print Your Name (Person signing consent form)	Signature (Patient or Other Legally Authorized Person)
		Relationship to Patient

Texas Tech University Health Sciences Center

Consent and Release to Use Image or Information

I, (print name) _____
or my authorized legal representative, hereby give consent for Texas Tech University Health Sciences Center (TTUHSC) employees, students or agents to take and use information about me (including my medical history, if applicable), my name or image or likeness including, but not limited to, photographs, videotaped images, audio recordings, digital (collectively "Images"), or my data or presentation for the purposes checked below.

I AGREE TO USES DESIGNATED BELOW: ***(Not including uses for patient treatment or payment.)***	My Name	My Image(s)	My Information	My Data or Presentation
☒ For educational purposes within TTUHSC.	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
☐ For educational purposes outside TTUHSC.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ For TTUHSC marketing or publicity (This includes news and social media such as interviews, Facebook, websites, Twitter, YouTube, etc.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ For publication in journals or on the Internet	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Other purpose(s):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I understand that TTUHSC and its regents, employees, agents, and personnel, acting on behalf of TTUHSC, shall not be held responsible for any use of my name, information and/or image(s), including any use whatsoever by any outside user or third parties, and I hereby release and hold harmless TTUHSC and its regents, employees, agents and personnel, acting on its behalf, from any and all liability for damages of whatever kind, character or nature which may at any time result from this Consent and Release authorizing use or dissemination in accordance with the above.

I understand that TTUHSC will own the image(s) of me for the purposes stated above. I do hereby knowingly and voluntarily waive any and all other rights, compensation, royalties, or payment of any kind or character in connection with the use of my name, likeness and/or image(s) as authorized above.

This Consent and Release can be revoked or withdrawn at any time, but such withdrawal or revocation must be in writing and sent to the TTUHSC Institutional Privacy Officer and/or local campus Regional Privacy Officer. Any withdrawal of consent does not affect any information used or disclosed prior to receipt of the written notice of withdrawal.

By signing below, I represent that I have read and understand this "Consent and Release to Use Image or Information" and that it is binding on my heirs, executors and personal representatives. I am 18 years of age or older.

_____ _____
Signature of Person Named Above Date

_____ _____
OR Signature and Print Name of Authorized Legal Representative Date

For Office Use Only:	Completed by: _____	
Date of Event: _____ ☐ Speaker	MR#: _____ ☐ Patient	R# (Banner): _____ ☐ Faculty ☐ Staff ☐ Student

* Educational purposes for training of residents/interns via video monitoring by the Board Certified Physician/ Licensed Professional Counselor Supervisor

Informed Consent Document for Psychotherapy

What Is Psychotherapy?

Psychotherapy is both a way of understanding human behavior and of helping people with their emotional difficulties and personal concerns and problems. Psychotherapy typically starts with an assessment of problematic symptoms and behaviors that often intrude into a person's social life, personal relationships, school or work activities, and physical health. A variety of psychotherapeutic strategies may be employed to address specific problems. Therapy is designed to help clients of all ages understand how their feelings and thoughts affect the ways they act, react, and relate to others. Psychotherapy can be relatively short-term when the focus is limited to resolve specific symptoms or problem areas, or longer term if the treatment focus targets more pervasive or long-standing difficulties.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have benefits such as better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

What Is Psychological Assessment?

Psychological assessment is a process of testing that uses a combination of techniques to help arrive at some hypotheses about a person and their behavior, personality and capabilities. Psychological assessment can help the therapist with diagnosis and/or treatment planning.

Confidentiality Statement for Psychotherapy Sessions

In addition to HIPAA protections and exceptions, information shared by you in a psychotherapy session is further protected by legal and ethical codes. This information is kept confidential with few exceptions. *Exceptions to confidentiality are rare, but may occur in the following situations:*

1. Abuse of Children, Elderly, or Disabled Persons. If the therapist has reason to believe that a child under the age of 18, an elderly person, or a disabled person is being abused or neglected, s/he is legally obligated to report this situation to the appropriate state agency.

2. Imminent Harm to Self. If a therapist has reason to believe that you are in danger of physically harming yourself, s/he may have to take action to protect you (such as contacting the police, notifying another person such as a family member, seeking involuntary hospitalization, or other actions).

3. Imminent Harm to Others. If a therapist believes you are an actual threat to the safety of another person/s, s/he may take action to ensure that the other person/s is protected (such as contacting the police, notifying the other person/s, seeking involuntary hospitalization, or other actions).

4. Reports of Sexual Exploitation by a Therapist.

5. Subpoena of records by a court.

6. Child under the age of 18. Children do not have full confidentiality from their parents.

Additional Information:

Availability: The therapist is available for regularly scheduled appointment times. Appointments can be made by calling the main office number (432-620-5800) during regular office hours. Emergency service can be obtained by calling 911 or going to the nearest hospital emergency room.

Termination of Treatment: Patients have the right to refuse or to discontinue services at any time and complaints can be addressed to the Texas State Board of Examiners of Psychologists, in Austin, Texas.

Fees: The fee for service generally covers a 50-60 minute session. If you have concerns about fees and payment, please discuss these concerns with TTUHSC billing or reimbursement staff. If you have insurance, please verify reimbursement

NEW PATIENT QUESTIONNAIRE FOR PSYCHOLOGY			Date:
Name:	Gender: M F	Birthdate:	Age:

Referred by: Self Referred Dr. Jain Dr. _____ Other _____

Reason for Visit – Primary Concerns:

1.

2.

3.

Goals for Therapy:

What is your Marital Status? Single Cohabitating Engaged Married Divorced Widowed

Who lives with you now?

Please provide the names and ages of any children you have.

What is your highest level of education?	**What is your occupation?**
Who raised you?	**Were your parents divorced at that time?**
What was your mother's occupation?	**What was your father's occupation?**

Please list your brothers' and sisters' first names and ages.

Please list any psychiatric medication you are currently prescribed and the name of the prescribing doctor. *(such as anti-depressant, anti-anxiety, sleep medications, etc.)*

Please list any psychiatric medication you have taken in the past.

How old were you when you were <u>first prescribed</u> any type of psychiatric medication?

What are your <u>current</u> mental health diagnoses? *(such as ADHD, Major Depression, Bipolar Disorder, Schizophrenia, Borderline Personality Disorder, Panic Disorder, None, Unknown, etc.)*

Which <u>other</u> mental health diagnoses have you been given <u>in the past</u>?

Are you in recovery from drug or alcohol addiction?		YES NO
How often do you drink alcohol?	How many drinks do you usually have?	How long have you been drinking at this level?
Is your drug or alcohol use an issue of concern for anyone around you?		YES NO
Have you used any recreational drugs in the past year? *(such as pot, synthetic pot, cocaine, meth, ecstasy, etc.)*		YES NO
Have you ever used any recreational drugs? *(such as pot, synthetic pot, cocaine, meth, ecstasy, etc.)*		YES NO
Have you had any traumatic experiences that continue to affect you? *(such as physical or sexual abuse, assault, near death experience, house fire, major car accident, earthquake, held at gunpoint, etc.)*		YES NO
If so, what type of traumatic experiences have you experienced?		
If so, in what way do they continue to affect you?		
Do you have any medical or physical problems or chronic/frequent pain?		YES NO
If so, please indicate condition and treatment:		
Have you ever physically harmed yourself on purpose? *(such as hitting, cutting, or burning yourself, head banging, etc.)*		YES NO
If so, please describe.		
Have you ever thought about killing yourself?		YES NO
If so, have you ever acted on these thoughts?		YES NO
If you have acted on these thoughts, what did you do?		
When you haven't acted on these thoughts, what kept you from doing so?		
When was the last time you thought about killing or seriously harming yourself?		

__ Self-esteem / self-confidence / self-respect
__ Are your thoughts broadcasted or can people hear what you're thinking?
__ Anxiety / fear / panic attacks
__ Anger / irritability / intense frustration
__ Feeling hopeless, helpless, or worthless
__ Hearing voices or seeing things that others do not seem to see or hear
__ Loss of pleasure or enjoyment of most things
__ Fatigue or tiredness
__ Feeling that others are out to get you or there are conspiracies against you
__ Racing thoughts
__ Suspiciousness
__ Do you have any special talents or powers that others don't seem to have
__ Talking so fast that people ask you to slow down
__ Feeling miserable most of the time
__ Being a perfectionist
__ Being a people pleaser
__ Do you have any special relationships with famous people?
__ Thoughts of suicide or homocide?