Robbie Wright, M.D., PLLC
4550 Post Oak Place Drive, Suite 320
Houston, Texas 77027
(713) 622-5480

CHILD AND ADOLESCENT PATIENT INFORMATION

This office utilizes an electronic health record. Please complete the information below to enable us to communicate with you according to our necessity and your preferences.

Name: _____ DOB: _____

Social Security Number: _____-_____-_____

Address: _____

City: _____ Zip Code: _____

Telephone Communications

Please only leave contact information for phone numbers where you would be willing to accept an incoming call from our office.

Mother's Name: _____

Mobile Phone: (_____)_____

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

Father's Name: _____

Mobile Phone: (_____)_____

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

Electronic Communications

Please only provide your email address if you consent to email communications with Dr. Wright.

Email address (print carefully): _____

Do you consent to electronic/email communication (i.e. via gmail or other non-encrypted accounts)?
Y N
Would you like to receive email appointment reminders as a courtesy from "Patient Fusion" (our health record)?
Y N *(please be advised that these emails may go into your spam/junk folder)*

- *Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.*

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- *No one can diagnose your condition from email or other written communications, and communication via our website cannot replace the relationship you have with a physician or another healthcare practitioner.*
- *Emails are checked during business hours only. If you have a matter that requires urgent attention after hours or on weekends, please call.*
- *Communications via email or other non-portal text are not encrypted, but are still considered part of your health record.*
- *Any text or email initiated by yourself is an implicit consent to receive electronic communications from our office within the same medium (i.e. sending an email to Dr. Wright's gmail account implies agreement to receive a reply via gmail).*

I have read, understood, and agree to the above guidelines on electronic communications.

Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

Late Cancellations, Missed Appointments, and Source of Payment

YOU WILL BE CHARGED FOR MISSED APPOINTMENTS UNLESS YOU PROVIDE 24-HOUR NOTICE. 24 HOUR NOTICE CAN BE GIVEN AT ANY TIME VIA EMAIL NOTIFICATION: **appointments@wrightpsychiatry.com**

PLEASE NOTE THAT INSURANCE WILL NOT REIMBURSE FOR MISSED APPOINTMENTS. BY SIGNING, YOU AGREE THAT ALL CHARGES ARE YOUR RESPONSIBILITY AND THAT FILING FOR OUT-OF-NETWORK INSURANCE REIMBURSEMENT IS YOUR RESPONSIBILITY IF YOU CHOOSE TO DO SO.

Signature of Guarantor: _____ Date: _____

Guarantor Name: _____ Relationship to Patient: _____

If different from patient information above:

Address: _____ Zip: _____

Cell No: (_____)_____ Business No: (_____)_____

Home No: (_____)_____

Emergency Communications

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____)_____

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Demographic and Clinical Information Regarding Mother

Name: _____ DOB: _____

Social Security Number: _____-_____-_____

Address (if different from child): _____

_____ Zip: _____

Employer: _____ Occupation: _____

Education: _____ Religion: _____

Marital Status: single married domestic partnership separated divorced widowed

Health Problems: _____

_____

Demographic and Clinical Information Regarding Father

Name: _____ DOB: _____

Social Security Number: _____-_____-_____

Address (if different from child): _____

_____ Zip: _____

Employer: _____ Occupation: _____

Education: _____ Religion: _____

Marital Status: single married domestic partnership separated divorced widowed

Health Problems: _____

_____

Demographic and Clinical Information Regarding Child/Adolescent

Current School: _____ Grade: _____

Any Accommodations Given in School? _____

_____

Religion: _____

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Please list all individuals living in your child/teen's household (including minors/children).

Name	Relationship	Age	Occupation

Please list all family members not living in your child/teen's present household (including parents, siblings, separated/divorced parents).

Name	Relationship	Age	Occupation

How were you referred? _____

Please briefly describe the problem or situation that has led you to seek treatment for your child/teen:

_____

_____

Has your child/teen experienced this problem before? If so, when and what treatment did you receive?

_____

_____

Do you have any particular treatments in mind? If so, what? _____

_____

Name of pediatrician: _____

Name of other current treating providers: _____

_____

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POINTS TO REMEMBER

Please initial by each statement:

_____ 1. Notify Dr. Wright if there are any significant changes in your child's psychiatric or medical condition.

_____ 2. Notify Dr. Wright if you suspect or know that your child is pregnant. Pregnancy will affect treatment recommendations.

_____ 3. If you feel your child is at any risk for hurting himself/herself or others, notify Dr. Wright immediately.

_____ 4. If medication makes your child drowsy or slows his/her reaction time, your child should refrain from driving and notify Dr. Wright. Also notify Dr. Wright if your child's medication causes other significant side effects.

_____ 5. If you want to increase, decrease, or discontinue your child's medication regimen, call first. Medication management is a collaborative process. Changes without consultation are potentially dangerous and may interfere with our ability to work together.

_____ 6. It is advised not to drink alcohol while taking psychiatric medications.

_____ 7. Please note our office does not provide reminder calls about upcoming appointments. You will be responsible for keeping track of them.

_____ 8. All cancellations should be made by emailing us at appointments@wrightpsychiatry.com. This will provide the most efficient manner of documenting your cancellation and making sure it is done in a timely manner to avoid any late cancellation fees.

_____ 9. We are here to help you. Do not hesitate to call if you have questions or concerns.

I have read and understand the preceding Points to Remember.

_____ _____
Patient Name DOB

_____
Parent or Guardian Name

_____ _____
Parent or Guardian Signature Date

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4550 Post Oak Place Drive, Suite 320
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who is Subject to This Notice

Robbie Wright, M.D., PLLC

II. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record for your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- Follow the terms of our Notice currently in effect.

III. Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person:

Privacy Officer
4550 Post Oak Place #320
713-622-5480

IV. Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information. Participants in this organized healthcare arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized healthcare arrangement.

V. Other Uses and Disclosures

In addition to uses and disclosures related to treatment, payment, and health care operations, we may also use and disclose your personal information without authorization for the following additional purposes:

Abuse, Neglect, or Domestic Violence

- As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Business Associates

- We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer systems, or do our billing. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

Communications with Family and Friends

- We may disclose information about you to persons who are involved in your care or payment for your care, such as family members, relatives, or close personal friends. Any such disclosure will be limited to information directly related to the person's involvement in your care.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Food and Drug Administration (FDA)

- We may disclose health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

Health Oversight

- We may disclose health information about you for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to our provision of health care, or to the health care system.

Judicial or Administrative Proceedings

- We may disclose health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.

Law Enforcement

- We may disclose health information about you to a law enforcement official for certain law enforcement purposes. Such disclosure will only occur when required by law.

Minors

- If you are an unemancipated minor under Texas law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

Notification

- We may notify a family member, your personal representative, or other person responsible for your care, of your location, general condition, or death.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgement to determine what is in your best interest regarding any such disclosure.

Parents

- If you are the parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.
- In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Personal Representative

- If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

Public Health Activities

- As required or permitted by law, we may disclose health information about you to a public health authority, for example, to report disease, injury, or vital events such as death.

Public Safety

- Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public.

Required By Law

- We may disclose health information about you as required by federal, state, or other applicable law.

Research

- We may disclose health information about you for research purposes in accordance with our legal obligations. For example, we may disclose health information without a written authorization if an Institutional Review Board (IRB) or authorized privacy board has reviewed the research project and determined that the information is necessary for the research and will be adequately safeguarded.

Specialized Government Functions

- We may disclose health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veterans' benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.

Workers' Compensation

- We may disclose health information about you for purposes related to workers' compensation, as required and authorized by law.

VI. Your Health Information Rights

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
- Request that we communicate with you by alternative means, such as making records available for pickup, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.
- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
- Request that we amend the health information about you that is maintained in our files and the files of our business associates (if applicable). Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of

reasonable length) disagreeing with the decision. This statement will be added to your records.

- Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not necessarily include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2003, to June 1, 2003). We will be unable to provide you an accounting for any disclosure made before April 14, 2003 or for a period of longer than six years.
- Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section III above for information). If you have questions about your rights, please speak with our contact person, available in person or by phone, during normal office hours.

VII. To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person (see section III above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint with HHS.

VII. Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting room of our office, make copies available to our patients and others.

IX. Effective Date:

July 1, 2009.

Robbie Wright, M.D., PLLC
4550 Post Oak Place Drive, Suite 320
Houston, TX 77027

Patient Name: _____ **Birth date**: _____

Maiden or other name (if applicable): _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of **Robbie Wright, M.D., PLLC** effective July 1, 2009.

Signature (patient or authorized representative): _____

Date: _____

Relationship/authority (if signed by authorized representative): _____

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4550 Post Oak Place Drive, Suite 320
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CONFIDENTIALITY

PLEASE READ CAREFULLY

Generally speaking, communications between a patient and mental health provider are confidential and may not be disclosed without your consent, or as otherwise provided by law.

There are exceptions to the general rule of confidentiality which would require that the mental health provider report his or her concerns without the consent of the patient. These occasions include, but are not limited to, the following:

- Belief that child abuse has or may occur
- Belief that an elderly or mentally handicapped person has been or may be abused
- Reports by a patient of possible sexual abuse or exploitation by a previous therapist

An instance where you are felt to pose an imminent danger to yourself or another person may result in a loss of confidentiality. Or, if you make your mental health a point of litigation you implicitly waive the right to confidentiality and your physician/therapist may be compelled to release your records, give a deposition, and/or testify in court.

Similarly, if you are involved in a suit affecting the parent-child relationship, your physician/therapist may be compelled to release your records, give a deposition, and/or testify in court.

Special rules apply to minors: By law, a parent has the right to the medical record of a child, unless this right has been limited by court action. Parents, on the other hand, may agree that during the course of treatment given to a minor child, they will waive the right to the medical record of their child. I have found that this waiver is helpful for useful clinical work to occur.

If you have any questions, or would like additional information please feel free to ask.

* *

ACKNOWLEDGMENT BY PATIENT AND PARENT/GUARDIAN

I have read the preceding and understand my rights as a patient.

_____ _____
Patient Name DOB

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

I am willing to waive my right of access to communication between my child and Dr. Wright and grant to Dr. Wright the discretion to determine when or if such communication would be shared with me.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

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PATIENT INFORMATION REGARDING PROFESSIONAL FEES

The purpose of this agreement is to allow us to focus on what is most important to all of us—helping you.

I understand that payment is expected at the time of delivery of service. You can pay by cash, check, or credit card. Checks should be made to **Robbie Wright, M.D., PLLC** since the office account is in the corporate name. Having the office charge your credit card at the time of service is encouraged because it simplifies the checkout process for you and the office.

I authorize Robbie Wright, M.D., PLLC to charge my credit card.

My credit card # is: _____

Expiration Date: _____/_____ Security Code: _____ Billing Zip Code: _____

I UNDERSTAND THAT I WILL BE CHARGED FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. NO EXCEPTIONS WILL BE MADE. All cancellations should be via email at appointments@wrightpsychiatry.com. You can send your message anytime, including after hours and on weekends, to avoid a late cancellation fee. I am aware that insurance will not cover charges for missed appointments or late cancellations.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE TO THIS OFFICE ALL INFORMATION NECESSARY TO OBTAIN PREAUTHORIZATION PRIOR TO TREATMENT.
I understand I will be charged for the time involved in obtaining preauthorization.

I agree to advise the receptionist when I come in of any change in my address, phone number, marital status, or responsible party that has occurred since my last appointment.

WE WANT TO BE CLEAR THAT THE FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDED IS YOURS AND THAT INSURANCE IS FOR YOUR REIMBURSEMENT. We do not bill the insurance company directly. Your statement contains the information needed to file your insurance.

It is our policy to designate one parent as financially responsible for services provided to children. If Court Orders (e.g. custody agreements) specify other financial agreements (e.g. each parent responsible for 50%), it becomes the responsibility of the designated parent to obtain reimbursement from their ex-spouse.

Although interest will not be charged routinely, we reserve the right to charge interest at the rate of 10% per annum and bill for all expenses incurred if your account has to be turned over to collections and/or an attorney.

If you have any questions regarding this agreement, do not hesitate to discuss it with your Dr. Wright.

_____ _____
Patient's Name Date

_____ _____
Responsible Party's Name (Print) Date

_____ _____
Responsible Party's Signature Date

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Professional Fees

as of January 1, 2018

PSYCHIATRIC ASSESSMENT/CONSULTATION (Adult: 18 and up):
45 minute appointment for initial diagnostic assessment. Appointment typically includes gathering history, arriving at a diagnosis and creating a treatment plan. **$375.00**

PSYCHIATRIC ASSESSMENT/CONSULTATION (Child: 12 and under):
The **first appointment** will be with the parents alone.

45 minute appointment for gathering complete medical history, psychiatric history, developmental history, educational history, social and family history. **$375.00**

The **second appointment** will be with the child alone.

45 minute appointment **$275.00**

The **third appointment** will consist of a feedback session to discuss diagnosis and treatment plan.

30 minute appointment **$175.00**

PSYCHIATRIC ASSESSMENT/CONSULTATION (Child: 13-17):
The **first appointment** will be with the adolescent and family together.

45 minute appointment for gathering complete medical history, psychiatric history, developmental history, educational history, social and family history. **$375.00**

The **second appointment** will include meeting with adolescent alone for 30 minutes followed by a feedback session to discuss diagnosis and treatment plan for an additional 30 minutes**. $275.00**

MEDICATION MANAGEMENT:
Up to 30 minute appointment to monitor response to psychopharmacological treatment. **$175.00**

PSYCHOTHERAPY: (Individual, Family, Parenting) $275.00
45 minute appointment to facilitate insight, interpersonal growth and/or develop problem solving skills. Appointment may be with the identified patient and/or family members. Appointments are usually scheduled on an ongoing and regular basis (e.g. weekly).

FORMS AND LETTERS:
Patients frequently request forms and letters for school, work, or insurance issues. If time permits, brief forms may be completed during your allotted appointment time and there will be no additional charge. Longer forms and letters will be done outside of appointment time and the fee will be based on the time involved to complete this service.

Simple	(less than 5 minutes)	No Charge
Moderate	(5-15 minutes)	**$75.00**
Lengthy	(15-30 minutes)	**$150.00**
Complex	(over 30 minutes)	**$250.00/Hour**

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PHONE CALLS:
Brief phone calls are an important part of monitoring an individual's response to treatment. These calls should be made during regular office hours and there is no fee. If I am not available to receive the call, I will make every effort to return the call that same day or evening. If calls are increasing in duration and frequency, this may be a sign that you need to be seen sooner. You will be asked to schedule an appointment. Non-emergent calls made after hours will be billed at **$300.00/Hour**.

COPYING RECORDS:
Upon written request, records will be copied. It typically takes a week to have copies made. Copies of charts can be picked up or mailed, but will not be faxed. The fee for copying is:

$25.00 for the first 20 pages
$0.50 for each subsequent page

FORENSIC PSYCHIATRY:
In most situations it is not appropriate for me to provide clinical care and forensic psychiatry services (i.e. consultation to an attorney or the Court) for the same individual. **Forensic services are billed at $600.00 an hour** and require a separate written agreement and retainer.

I acknowledge Dr. Wright's current fee schedule. I recognize fees are subject to change without notice.

_____
Patient Name

_____
Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date

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Authorization to Use/Disclose Health Care Information

Patient Name: _____ **Birth date:** _____

Maiden or other name (if applicable): _____

I request and authorize **Dr. Robbie Wright** to release my health care information and/or to obtain health care information from the following: (please list information for your primary care doctor, child's pediatrician, or you or your child's therapist)

Name: _____ **Phone:** _____

Address: _____

City, State: _____ **Zip code:** _____

This request and authorization applies to only the following protected health information:

_____ History / Physical Exam _____ Laboratory Reports _____ Consultations

_____ Discharge Summary _____ Doctor's Orders _____ Progress Notes

_____ Psychiatric Reports / Tests _____ Psychological Reports _____ Billing Records

_____ Initial Psychiatric Evaluation _____ Other: _____

during the following time period or dates: _____ (example: ongoing during treatment)

Each disclosure made with the patient's written consent must be accompanied by the following written statement:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

Purpose(s) of this use/disclosure: **continuity of care and collaboration**

Authorization expires: _____ (example: end of treatment or in one year)

I understand that, unless action has already been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Robbie Wright, M.D.

I understand that Dr. Wright may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

Signature (patient or authorized representative): _____ **Date:** _____

Relationship/authority (if signed by authorized representative): _____

I have received a copy of this signed authorization: (please initial) _____ yes _____ no

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018 MC-263
Austin, TX 78768-2018

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information please visit our website at

www.tmb.state.tx.us