LifeSpring
BEHAVIORAL HEALTH

1400 Woodloch Forest Drive, Suite 575, The Woodlands, TX 77380
Office: 281-528-1523 Fax: 281-719-0491

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip_____

Phone #_____Email_____

May we text you? Y N May we email you? Y N

Emergency Contact_____Relationship_____

Phone # _____Do we have consent to contact your Emergency Contact? Y N

Physician_____ Phone # _____

Other Physician_____ Specialty_____ Phone # _____

Therapist _____ Phone # _____

Referred by _____

Minor's Guardian Information:

Guardian's Name_____Relationship_____

Guardian's Phone # _____

PAYMENT

1. **Payment is required at the time of service.** We accept Visa/MasterCard/Discover/American Express, cash, check, or Venmo. **There is a $35 fee for returned checks.**
2. In order to provide longer sessions, **we do not file with insurance.** We will provide you a statement with the necessary information should you choose to file for possible out-of-network benefits.
3. **We have a 24 business-hour cancellation policy, so please reschedule or cancel any appointment at least 24 business-hours in advance to avoid a missed appointment fee. REMEMBERING YOUR APPOINTMENT IS YOUR RESPONSIBILITY. Your credit card on file will be billed 50%-100% of the appointment fee, depending on the circumstances for no-shows and late cancellations.**
4. **Existing balances must be paid before further services will be provided.**
5. Brief phone calls concerning scheduling, payment, and medication safety concerns are at no charge. **We do bill for other phone calls ($50 minimum).**

6. **All medication refills will be provided only during scheduled appointments. Before you cancel, make sure you have enough medication to last until you can be seen.**

By initialing, you agree to all of these terms. (Initial _____)

CONFIDENTIALITY

1. We will not release information about you without your permission unless we believe there is an emergency or we are ordered by a court.
2. We may disclose health information about you if required by law or state or federal regulations, or to report suspected abuse or neglect of a child or compromised elderly adult.
3. We may be obligated to take action to protect a patient or others from harm. If there is a threat of harm to one's self or others, your physician may be obligated to help arrange hospitalization or contact appropriate persons who can help provide protection.
4. If you choose to file with your health insurance company, they will likely require a diagnosis to justify payment. Any diagnosis made will become a part of your permanent health record.
5. Email is not secure; therefore, we only use it for routine matters, not psychotherapy.

TELEHEALTH SERVICES

1. Telehealth services may be offered if you are interested and your provider deems this is an appropriate service based on the clinical situation, co-existing medical and/or psychiatric conditions, and logistical factors.
2. Telehealth services are provided under similar privacy policies as in-person appointments.
3. A telehealth session cannot be exactly the same, and may not be as complete as a face-to-face service, which could possibly result in errors in judgment given the restricted information available to your provider.
4. You have the right to stop using telehealth at any time, including in the middle of an appointment, and to request to schedule an in-person appointment.
5. You agree to not record any telehealth session without written consent from your provider, nor will your provider record any session without your written consent.
6. You agree to inform your provider if any other person can hear or see any part of your session before the session begins, as your provider will inform you if any other person can hear or see any part of your session.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to confidential matters, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you nor your attorney, nor anyone else acting on your behalf, will call us to testify in court or at any other proceeding, nor will a disclosure of records be requested.

CONTACTING US

1. For scheduling or billing matters, please contact our office.
2. For medication questions, please contact your provider.
3. Medication refills will be provided during appointments only. You will be provided the number of refills deemed appropriate until your next appointment. If no refills remain, please schedule an appointment.
4. If you have an emergency, you may need to go to the nearest emergency room or call 911. Please do not email your provider or wait until our voicemail is checked.

COMPLAINTS

1. Please discuss with us any concerns or complaints you may have as soon as possible so we can work towards a resolution. Expressing anger or disappointment can strengthen our doctor-patient relationship and enhance the possibility of a successful outcome.
2. If you become dissatisfied with our services and we cannot resolve the issue, you may report complaints to the Texas Medical Board or the Texas Board of Nursing. Their contact information will be provided to you upon request.

MAXIMIZING RESULTS

1. Please arrive on time for your appointment. This helps us stay on schedule and minimizes the time you and others have to wait and it ensures you receive your full allotted time. We do our best to respect your time, but ask for your patience in advance if we are running behind due to an urgent matter.
2. Success in therapy depends on your desire for change and on your willingness to be honest with yourself and with us. Awareness of need, willingness to feel and to talk about negative emotions, curiosity, and openness to direction will maximize your benefit from our doctor-patient relationship.
3. We believe complete healing relies on a solid foundation of health to include aligning the mind, body, and spirit. Research shows that regular exercise, a healthy diet, mindfulness and other lifestyle changes can improve overall health and quality of life. We will try to include lifestyle changes into your treatment plan when indicated. If you would like, spirituality and prayer can also be a part of your visit. Please let us know if this is your desire.

Our mission is to provide you high-quality care with honesty and integrity. Your signature below indicates that you have read and agree to the above terms. We consider it an honor that you have chosen us to be your provider. Thank you for allowing us to work with you.

_____

Patient Name (Printed)

_____ _____

If Patient Representative, Name (Printed) Relationship to Patient

_____ _____

Signature Date

COMMUNICATIONS CONSENT

I, _____, give written consent to the clinicians and staff of LifeSpring Behavioral Health to collaborate as it pertains to my confidential medical and mental health care, including any substance use disorders, to ensure my comprehensive care. I also give consent to discuss such information with the following people:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

I understand that this will remain in place until revoked in writing. _____
Signature

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of our Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information contained therein, please do not hesitate to contact the office as indicated on your Notice.

_____
Patient Name (Printed)

_____ _____
If Patient Representative, Name (Printed) Relationship to Patient

_____ _____
Signature Date

LifeSpring
BEHAVIORAL HEALTH

1400 Woodloch Forest Drive,
Suite 575
The Woodlands, TX 77380
281-528-1523

GOOD FAITH ESTIMATE - MEDICAL

FOR INFORMATIONAL PURPOSES ONLY. As required by law, this is our notification to you of the possible costs of our services. No action is needed from you. If you have any questions, please contact our office.

Diagnosis: To be determined at initial evaluation

New Patient Evaluation	90792	60-90 minutes	$375-$400
Psychotherapy	90833	20-50 minutes	$150-$375
Medication Management	99214	20-30 minutes	$150-$195
Injection	96372		$50-$75
Report	99080		$25-$250
Urine Test	80305		$28
Genetics Testing			$191-$465

Dates of Service: Initial Evaluation and Regularly Scheduled Follow-ups.

Estimated Cost Per Year - $400 - $3000

Tax ID: 26-2875640

Peter A. Johnson, MD	NPI 1710148176
Kathryn Rutland, MD, MPH	NPI 1851586176
Hilary Butella, DNP, APRN, PMHNP-BC, FNP-C	NPI 1295221810
James Michael Smith, DHSc, MPAS, PA-C, CAQ-Psychiatry	NPI 1023078052
Quinn Walkley, PMHNP-BC	NPI 1548981970

This Good Faith Estimate (GFE) shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The GFE does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If you are billed for more than this GFE, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the GFE. You can ask them to update the bill to match the GFE, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this GFE. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.