

LifeSpring

BEHAVIORAL HEALTH

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

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone # _____

Email _____

May we text you? Y N

May we email you? Y N

Emergency Contact _____

Relation _____ Contact # _____

Physician _____ Contact # _____

Other Physician _____ Specialty _____ Contact # _____

Therapist _____ Contact # _____

Insurance Company _____ I.D.# _____ Contact # _____

Referred by _____

PAYMENT

1. Payment is required at the time of service.

We accept cash, check, or Visa/MasterCard/Discover/American Express. **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 with a statement with the necessary information for you to file for possible out-of-network benefits, if you wish.

3. Brief phone calls concerning scheduling, payment, and medication safety concerns are at no charge. **We do bill for other phone calls (\$50 minimum).**

4. Existing balances must be paid before further services will be provided.

5. 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 charged. Fees are \$50 for follow-up appointments, and 50% of the fee for new-patient appointments.

- 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 permissions 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 of 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 providers 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 manner.
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 with 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 LifeSpring Behavioral Health to discuss my confidential information, including my mental health, with the following individuals:

<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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



719 Sawdust Road, Suite 207
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	\$325-\$375
Psychotherapy	90833	20-50 minutes	\$125-\$350
Medication Management	99214	20-30 minutes	\$125-\$175
Injection	96372		\$50-\$60
Report	99080		\$20-\$200
Urine Test	80305		\$28
Genetics Testing			\$184-\$451

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

Estimated Cost Per Year - \$375 - \$2500

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
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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.