LifeSpring Behavioral Health

719 Sawdust Road, Suite 207
Spring, TX 77380

Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

SSN_____

Home # _____ Cell #_____Work #_____

Where do you prefer messages to be left? _____ May we text you? Y N

Email _____ May we email you? Y N

Emergency Contact_____ Relation _____ Contact #_____

Physician _____ Contact #_____

Other Physician_____ Specialty_____ Contact #_____

_____ 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 of half of the appointment charge. REMEMBERING YOUR APPOINTMENT IS YOUR RESPONSIBILITY. Your credit card on file will be charged.**
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 or 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 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 toward 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 appointments. 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 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

LifeSpring Behavioral Health

719 Sawdust Suite 207
Spring, TX 77380

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