AARON H. FINK, M.D., P.A.
Child, Adolescent, Adult and Sports Psychiatry
4550 Post Oak Place, Suite 320 • Houston, Texas 77027
www.aaronhfinkmd.com
713-622-5480

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.

Mobile Phone (_____)_____

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

Electronic Communications

Please only provide your email address if you consent to be connected to our patient portal (to view upcoming appointments, etc.) or consent to email communications with Dr. Fink.

Email address (print carefully) _____

Do you consent to electronic/email communication via our patient portal with Practice Fusion Electronic Health Record? **Y** **N**
Do you consent to electronic/email communication outside the portal (i.e. via gmail or other non-encrypted accounts)? **Y** **N**

- *Please keep in mind that communications vio email over the internet ore not secure. Although it is unlikely, there is a possibility thot informotion you include in an email can be intercepted ond read by other porties besides the person to whom it is addressed.*
- *No one can diagnose your condition from emoil or other written communications, ond communication via our website connot replace the relationship you have with a physicion or another healthcare practitioner.*
- *Emoils are checked during business hours only. If you have o matter that requires urgent attention after hours or on weekends, please call.*
- *Communications via our portal are encrypted and automatically become o port of your electronic health record.*

- *Communications via email or other non-portol 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. Fink's email account implies agreement to receive a reply via email).*

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

Signature _____ Date _____

Late Cancellations, Missed Appointments, and Source of Payment

YOU WILL BE CHARGED FOR MISSED APPOINTMENTS UNLESS YOU PROVIDE 24-HOUR NOTICE. 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 REIMBURSMENT 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: _____

Demographic and Clinical Information

Employer _____ Occupation _____

Education _____ Religion _____

Marital Status: single married domestic partnership separated divorced widowed

Name of Spouse/Partner (if not listed as emergency contact above): _____

Spouse/Partner Occupation _____ Phone _____

Please list all individuals living in your household (including minors/children).

Name	Relationship	Age	Occupation

Please list all family members not living in your present household (including parents, siblings, children, separated/divorced partners).

Name	Relationship	Age	Occupation

How were you referred? _____

Please briefly describe the problem or situation that has led you to seek treatment:

_____

_____

Have you 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 primary/family doctor: _____

Names of other current treating providers: _____

_____

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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

Aaron H. Fink, M.D., P.A.

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 of 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 health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care 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 to 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 judgment to determine what is in your best interest regarding any such disclosure.

Parents

- If you are a 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 pick-up, 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 disclosures 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.

VIII. 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 informatiou, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area of our office, make copies available to our patients and others.

IX. Effective Date:

April 14, 2003

AARON H. FINK, M.D., P.A.
Child, Adolescent and Adult Psychiatry
4550 Post Oak Place, Suite 320 • Houston, Texas 77027
713-622-5480

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 Aaron H. Fink, M.D., P.A., effective April 14, 2003.

Signature (patient or authorized representative):_____

Date: _____

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

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. It will also help in maintaining a lower fee schedule and clarifying your responsibilities.

I understand that payment is expected at the time of delivery of service. I authorize Aaron H. Fink, M.D., P.A. to charge my credit card.

My credit card # is _____Exp. Date_____ CVV_____

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 **CALLED** into our office. Feel free to leave a message afterhours 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 arrangements (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 doctor/therapist.

_____ _____

Patient's Name Date

_____ _____

Responsible Party's Name (Print) Date

_____ _____

Responsible Party's Signature Date

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

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

_____ _____

Patient Signature Date

I am willing to waive my right of access to communication between my child and their physician/therapist and grant to the physician/therapist the discretion to determine when or if such communication would be shared by me.

_____ _____

Parent's Signature Date

_____ _____

Parent's Signature Date

POINTS TO REMEMBER

1. Notify Dr. Fink if there are any significant changes in your psychiatric or medical condition.

2. Notify Dr. Fink if you suspect or know that you are pregnant or if you plan to become pregnant in the near future. Pregnancy will affect treatment recommendations.

3. If you feel you are at any risk for hurting yourself or others, notify Dr. Fink immediately.

4. If your medication makes you drowsy or slows your reaction time, refrain from driving and notify Dr. Fink. Also notify Dr. Fink if your medication causes you other significant side effects.

5. If you want to increase, decrease, or discontinue your 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 to not 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. 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 or Guardian Signature Date