CALLIE EMERY, M.D., P.A.
Child, Adolescent and Adult Psychiatry

12880 Hillcrest Road, Suite 104
Dallas, TX 75230
OFFICE 214-866-0338
FAX 972-490-3567

PATIENT INFORMATION: DOB: ____/____/____ Sex:_____

Name:_____

SS#:_____

Address:_____City:_____State:____Zip:_____

Home Telephone: (____) _____ Work Telephone: (____)_____

Mobile Telephone: (____)_____ FAX: (____)_____

May we leave messages for you at these phone numbers? Yes_____ No_____

If so, which number do you prefer we use?_____ **Pharmacy #:** _____

Names of all parents/guardians:_____

Which parent(s) have the legal right to consent to psychiatric/ medical care?:_____

PERSON RESPONSIBLE FOR BILL IF OTHER THAN THE PATIENT:

Name:_____

SS#:_____

Address:_____City:_____State:____Zip:_____

Home Telephone: (____) _____ Work Telephone: (____)_____

Mobile Telephone: (____)_____ FAX: (____)_____

Relationship to the patient: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name:_____ Relationship to the patient:_____

Home Telephone: (____)_____ Work Telephone: (____)_____

Mobile Telephone: (____)_____

PRIMARY CARE PHYSICIAN:

Name:_____ Telephone: (____)_____

Address:_____City:_____State:____ Zip:_____

REFERRED BY:

Name:_____ Telephone: (____)_____

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OFFICE POLICY

Dr. Emery schedules her own appointments. Payment is due at the time of the visit. You will receive a monthly statement that will include the diagnostic and procedural codes necessary for filing your own insurance. You are financially responsible for charges incurred regardless of insurance reimbursement policies.

The charge for a 90-minute initial evaluation or consultation appointment is $450. Many evaluations are done over time as a series of five to seven 45-minute sessions. Additional charges will be incurred if formal reports are requested. The charge for on-going psychotherapy is $225 per 45-minute session. The charge for medication follow-up appointments ranges from $200-$225 depending on the length of appointment (25 or 45 minutes). If significant collaboration is needed outside of sessions in the form of phone calls with the patient or family members responsible for their care or other professionals, a charge will be incurred based on time allocated. Phone calls lasting longer than 15 minutes will be charged accordingly.

As mentioned previously, payment is due at the time of the visit. Cash, check, Visa, Mastercard, or Discover are accepted. Credit cards can be used by filing your number and authorization below. Accounts not paid by the next billing cycle are subject to a service charge of $20.00 unless previous arrangements have been made with Dr. Emery. If payment is not provided at the time of a visit (such as a check is rejected or an appointment is not kept and then payment is not sent in), then an authorized credit card will be required to be placed on file prior to future appointments. This credit card can serve as your preferred (primary) method of payment or simply as a filed back-up method.

Cancellation or rescheduling is required 24 hours in advance to avoid being charged for the reserved appointment time. You are financially liable for the full fee if you fail to cancel your appointment 24 hours in advance. It is the patient's responsibility to know appointment times.

After-hours calls will be returned for emergencies only. If there is an immediate medical emergency, please go to the nearest emergency room or call 911, if necessary. For other non-urgent calls, please leave both daytime and after-hours phone numbers where you can be reached. Please allow 48 hours for processing of medication refills. There will be a $20 refill charge for prescriptions that require written refills between appointments. If you will need monthly written refills to be mailed please provide self-addressed envelopes to keep on file.

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Dr. Emery does not testify in court, but if legal actions occur in which she is requested or subpoenaed to provide testimony (such as in a custody case) you will be responsible to provide the following even if the subpoena is sent from the opposing side of the case and even if your ongoing relationship with Dr. Emery has ended:

1. Travel expenses.
2. Hourly or per diem fees based on Dr. Emery's then current session rates, plus 20% of that fee, from the time Dr. Emery leaves the office until her return.
3. Fees at Dr. Emery's then current rates, plus 20% of that fee, for the time expended in preparation and research. At least $2,000.00 will be due prior to the court appearance.
4. Record copying fees are $1.50 per page plus $225 per hour copying fee.

Please Read and Initial:

I understand that I am financially liable for the full fee if I fail to cancel my appointment 24 hours in advance. _____

I understand that I am ultimately financially responsible for charges incurred regardless of insurance reimbursement policies. _____

I authorize the release of any medical or health-related information to process insurance claims. _____

I have read and understand this Office Policy.

_____ _____
Signature (parent if minor) Date

Patient's Name:_____
Date of Birth:_____

02/01/2018

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(Patient Copy) - OFFICE POLICY

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I understand that I am ultimately financially responsible for charges incurred regardless of insurance reimbursement policies. _____

I authorize the release of any medical or health-related information to process insurance claims. _____

I have read and understand this Office Policy.

_____ _____
Signature (parent if minor) Date

Patient's Name:_____
Date of Birth:_____

02/01/2018

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Patient's Name:_____
Date of Birth:_____

CREDIT CARD AUTHORIZATION

If you would prefer to pay by credit card, please list below:

VISA/ MASTERCARD/ DISCOVER (CIRCLE ONE)

_____ _____
Name as written on card Expiration Date

_____
Credit Card Number

_____
Credit Card ID (3digit code on back of card)

_____
Billing Address & Zip Code for this card

I hereby give my authorization and consent for the above listed card to be used for payment to Callie Emery, MD. The billing charge will reflect the service rendered including additional services and will be present on the monthly physician billing statement. I understand that I am financially liable for fees incurred due to failure to cancel appointments 24hrs in advance. (Please be aware that the date(s) listed on your credit card statement will reflect the date of charge processing, not necessarily the actual date of service – since not all fees are processed on the date of service.)

Signature: _____ Date: _____

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CONSENT FOR TREATMENT

RE: _____ _____
Last Name First Middle Date of Birth

Choose one: **A.)**

I certify that I am the father, mother, legal guardian of the
(Circle one)

above named child and I hereby give my authorization and consent for the above named child to receive psychiatric outpatient diagnostic and treatment services. I also certify that I am legally authorized to provide this consent.

B.)

I hereby give my authorization and consent to personally receive psychiatric outpatient diagnostic and treatment services. I also certify that I am legally authorized to provide this consent.

Witness: _____ Father: _____

Date: _____ Mother: _____

OR

SELF / Legal Guardian: _____

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RELEASE OF INFORMATION CONSENT FORM

I, _____, hereby authorize Dr. Callie Emery to disclose records
(Patient or Legal Representative)

and/or exchange information concerning _____ to:
(Client)

PLEASE CHECK

_____ **School:** _____

Contact Person: _____ Phone #: _____

_____ **Medical Doctor:** _____

Address: _____

_____

Phone Number: _____

_____ **Therapist:** _____

Address: _____

_____

Phone Number: _____

_____ **Other:** _____ Phone #: _____

Address: _____

_____

_____ _____
Signature of Patient or Legal Representative Date of Signature

_____ _____
Relationship of Legal Representative Patient's Date of Birth

This consent may be revoked by client in writing at any time.

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Name:_____
Date:_____

MEDICAL HISTORY REVIEW QUESTIONNAIRE

Current Medical Care:

Are you or have you ever been under the care of a physician for any type of medical problem? If so, please explain.

Approximate date of last checkup:_____
Name of Doctor: _____
Included in checkup: (circle) blood tests urine tests EKG pap smear
Approximate date of last dental exam:_____

Medication:

Please list all medications (prescription & non-prescription) that you are currently taking.
Please list dosage if known:

_____
_____
_____

Please list all allergies, including those to medication_____

Hospitalizations & surgeries/ Past Medical History:

Please list any and all surgeries (problem/year):

Please list any other hospitalizations (problem/year):

Please list any other major illnesses you have had (hepatitis, HIV, etc. include date):

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Name:_____

For Women:

Onset of puberty: _____
Are you having periods? (circle) Yes No
Date of last menstrual period: _____
Menses: (circle) Normal Heavy Irregular
Have you ever been diagnosed with dysfunctional uterine bleeding (DUB)? Yes/No
Possibility of current pregnancy? (circle) Yes No
Pregnancies:
Number_____ Miscarriages_____ Abortions____ Complications_____
History of sexually transmitted disease?_____
Date of last pap smear_____
Birth control pills? (please specify type) _____
Recent change in sexual functioning? (circle) Yes No

For Men:

Onset of puberty? _____
History of sexually transmitted disease?_____
Recent change in sexual functioning? (circle) Yes No

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Name:_____

REVIEW OF SYSTEMS

Have you had any recurrent fever?	Yes/No
Do you have frequent headaches?	Yes/No
Have you had a recent change in your vision or hearing?	Yes/No
Have you ever had numbness, severe muscular weakness?	Yes/No
Have you ever had trouble with dizziness?	Yes/No
Do you have trouble with walking or balance?	Yes/No
Have you had blackout spells?	Yes/No
Have you had seizures or tics?	Yes/No
Have you ever had a traumatic brain injury, loss of consciousness?	Yes/No
Have you had unusual sensitivity to heat or cold?	Yes/No
Have you ever been diagnosed with thyroid disease?	Yes/No
Do you have trouble breathing, asthma?	Yes/No
Do you have chronic cough or have you coughed up blood?	Yes/No
Do you have chest pains or any type of heart problems?	Yes/No
Do you have high blood pressure?	Yes/No
Do you have any abdominal pains, change in bowel habits, or rectal bleeding?	Yes/No
Do you have difficulty or pain with urination?	Yes/No
Do you have any blood in your urine?	Yes/No
Do you have arthritis?	Yes/No
Have you had frequent ear infections?	Yes/No
Have you had frequent sore throats?	Yes/No
Have you had severe rashes or skin disorders?	Yes/No
Do you have ongoing dental problems?	Yes/No

Current weight_____ Weight one year ago_____

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Name:_____

PSYCHIATRIC HISTORY REVIEW QUESTIONNAIRE

Current Reason for Seeking Treatment (Greatest concern / How you think Dr. Emery may be able to help the most):_____
_____

Past Mental Health Care:

Have you ever been diagnosed with a mental health issue? If so, please explain.

Approximate date of last visit:_____
Name of Psychiatrist/Therapist: _____

Please list past psychoactive medications tried (prescription & non-prescription). Please list dosage, approximate dates of use, & any side effects if known:

_____
_____
_____

Have you ever had a psychiatric hospitalization? (diagnosis/year):

Have you ever attempted to take your own life?

Do you smoke?_____How much?_____How long?_____
Do you drink alcohol? (circle)
Never less than one drink daily 1-2 daily more than 2 daily
Have you ever drunk more heavily than you do now?_____
Have you ever taken unprescribed drugs (including "street drugs" or medications that were prescribed for another person)?_____

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Name:_____

FAMILY HISTORY (Medical and Psychiatric):

Including any of the following or other issues. If yes, please explain.

Heart disorders (hypertension, heart attacks)?	Yes/No
Sudden cardiac deaths at an early age?	Yes/No
Lipid disorders (high cholesterol)?	Yes/No
Endocrine disorders (diabetes, thyroid disorder)?	Yes/No
Cancers (brain tumors, etc.)?	Yes/No
Mood disorder (depression, bipolar disorder)?	Yes/No
Anxiety disorder (panic attacks, phobias)?	Yes/No
Attention-deficit / Hyperactivity disorder (inattentive)?	Yes/No
Psychotic disorder (schizophrenia, delusions)?	Yes/No
Suicide attempts/ completions?	Yes/No
Substance abuse disorders (alcohol, tobacco, other drugs)?	Yes/No
Eating disorder (bingeing, purging, abnormal weight gain or loss)?	Yes/No

Any other family health issues?

_____

_____

_____

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Name:_____

PEDIATRIC CARDIAC RISK ASSESSMENT FORM

Patient History Questions:	***Yes***	***No***
Has your child fainted or passed out DURING exercise, emotion or startle?		
Has your child fainted or passed out AFTER exercise?		
Has your child had extreme fatigue associated with exercise (different from other children)?		
Has your child ever had unusual or extreme shortness of breath during exercise?		
Has your child ever had discomfort, pain or pressure in his chest during exercise?		
Has your child ever been diagnosed with an unexplained seizure disorder?		
Has your child ever been told they have a heart murmur?		
Family History Questions:		
Are there any family members who had an unexpected, unexplained death before age 50? (include SIDS, car accident, drowning, others)		
Are there any family members who died of heart problems before age 50?		
Are there any family members who have had unexplained fainting or seizures?		
Please explain more about any "yes" answers here:		

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PF-1000 **HIPAA Required Form**

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

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Individual Rights: You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Practice Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address shown below. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer: Callie Emery, M.D. (address above)

Effective Date: This Notice is effective on or after 01/01/2009

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Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

The information covered by this authorization includes: (check if applicable)

_____ all information in my files, or _____

Purposes of Disclosure

Information listed above will be disclosed for the following purposes: (check if applicable)

_____ education, discussion of treatment plan, medical decision making, or_____

Persons to Whom Information May **Be Disclosed**

Information described above may be disclosed to:

_____ All entities listed on Release of Information Consent Form

_____

Name of other person/organization / Relationship

Expiration Date of Authorization

This authorization is effective unless and until revoked by me or my personal representative.

Right to Terminate or Revoke Authorization

I may revoke or terminate this authorization by submitting a written revocation to Callie Emery, M.D. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Individual

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

_____ _____

Signature of Patient or Legal Representative | Date of Signature

_____ _____

Relationship of Legal Representative | Patient's Date of Birth

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Effect of Refusing Authorization
If you refuse to sign this authorization, our practice will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

_____
Treatment conditioned on authorization

Signature (Note: This page to be signed only if refusing/limiting authorization)

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

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Acknowledgement of Receipt of Notice of Privacy

I have reviewed your office's Notice of Privacy, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy. I understand you may modify the Notice of Privacy at any time.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient