SAN ANTONIO
Family Psychiatry

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Demographics

Patient Name: _____ Date: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Preferred Method of Contact: Home ☐ Work ☐ Cell ☐

Home Phone: (____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Date of Birth: _____ Gender: Male / Female / Other Social Security Number: _____

Name of Referring Physician, Therapist or other source: _____ Telephone: (_____) _____

Marital Status: Single Married Divorced Separated Widowed Patient is: (circle, if applicable) Employed/Student

If Patient is a Student, Name of School: _____ Phone: (_____) _____

If Employed, Employer: _____ Occupation: _____ Phone: (_____) _____

IF PATIENT IS A CHILD:

Father's Name: _____ Work Phone: (____)_____ Employer: _____

Mother's Name: _____ Work Phone: (____)_____ Employer: _____

IF PATIENT IS MARRIED: Spouse's Name: _____ Work Phone: (____) _____ Employer: _____

RESPONSIBLE PARTY: Name: _____ Address: _____ Relationship: _____

Social Security Number: _____ Employer: _____

Driver's License Number of Responsible Party: _____ State of License: _____ DOB: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Pharmacy Name, Location and Phone Number: _____

EMERGENCY CONTACT: _____ Phone: (____) _____ Relationship: _____

Insurance Information:

Primary Insurance Name: _____ Policy ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship: _____

Secondary Insurance Name: _____ Policy ID #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

SAN ANTONIO
Family Psychiatry

Clinic Information, Financial Policy & Consent to Treat

Welcome to San Antonio Family Psychiatry! We are committed to providing exceptional psychiatric care to our patients. We have outlined our financial and office policies below. Please review this information thoroughly. Should you have any questions you may contact our office.

Payment for services is due at the time of service. This may include co-pays, unpaid balances, deductibles, co-insurance and fees that are due at the time of your visit. We accept cash, debit, and all major credit cards.

1) *Fees & Payments*

a. *ASSIGNMENT OF BENEFITS:* **I** hereby authorize my insurance benefits to be paid directly to San Antonio Family Psychiatry and understand that I am financially responsible for all co-pays, deductible amounts, and non-covered services. I also authorize San Antonio Family Psychiatry to release any information to my insurance company needed to process claims.

b**.** *NEW PATIENTS:* We require a refundable reservation fee of $100 to schedule your first appointment. If you have in-network insurance, this fee may be refunded to you at your first appointment (depending on your insurance plan/coverage); you will then be charged for your visit in accordance with your insurance plan/coverage. For private pay patients (including those with out-of-network insurance), the registration fee is applied to your New Patient appointment, and the remaining balance is due at the time of your visit. If you are being evaluated for ADHD, you are required to take our Creyos ADHD assessment. The assessment fee is $75, and your deposit may be applied in your assessment fee.

c. *MISSED/CANCELLED APPOINTMENTS:* For **NEW PATIENTS**: we ask that you cancel your first appointment no later than **3** business days before your scheduled appointment by speaking to a staff member. Late cancellation of your appointment will result in your $100 reservation fee deposit not being refunded. You have 10 minutes to show for your scheduled visit after the initial start time. If you are not present within those 10 minutes, it will be considered a no show and you will be required to pay another deposit in order to reschedule. **ESTABLISHED PATIENTS**: patients are asked to cancel at least 24 hours in advance of the scheduled appointment time. A $50 late fee will be charged for same day cancellations. If you do not show up for your scheduled appointment time, you will be charged a $100 no show fee. **All New Patient Paperwork must be completed and sent to our office three business days prior to your appointment. If it is not received promptly, your appointment will be canceled.**

d**.** *MEDICATION REFILLS:* Please contact our office. You must be seen regularly (usually not less than every 3 months) for proper monitoring of your condition and the medications prescribed. Medication will not be filled after hours or weekends. A charge of $30 will be applied to prescriptions that are written between appointments. For controlled medications, please refer to the controlled medications agreement.

e**.** *MEDICAL RECORDS***:** To **r**equest copies of your medical record, a release of information form must be signed. Your request will be fulfilled within 15 business days upon receipt of the medical release form. Fees: Per rules adopted by the Texas State Board of Medical Examiners: $25.00 for the first 20 pages, $.50 cents for each page thereafter.
No charge Doctor to Doctor/Hospital. Charges will be assessed for Letters and completion of forms.

a. *PATIENT PORTAL:* **All patients must have an active Patient Portal.** The patient portal is the preferred place to sign the New Patient Paperwork (Esign) as well as to complete clinical follow forms for your provider.

b. *TELEMEDICINE POLICY:* We offer Telehealth appointments after your initial appointment. Telehealth services include the use of HIPPA compliant videocall equipment and devices that enable health care providers to deliver virtual services to patients. We require a once a year in-office visit.

c. *CHANGE OF INFORMATION:* Please provide us with any change of your address, phone number or insurance information as soon as possible.

d. *URINE PRESCRIPTION MONITORING:* Urine prescription monitoring will be conducted on all new patients and periodically on patients taking controlled substances. Patients with drug screens positive for illicit substances will not continue to take controlled medications.

e. *AFTER HOURS CARE:* **In a life-threatening emergency, please call 911.** For urgent non-emergency matters please call our office number (210)-492-1666 and leave a message with our office. Calls will be returned on the following business day.

f. *TERMINATION OF DOCTOR/PATIENT RELATIONSHIP:* The provider reserves the right to terminate the doctor/patient relationship at their discretion. Reasons for termination may include but are not limited to failure to follow treatment plan, untimely unpaid balances, history of missed appointments, tampering or refusal of drug screen, verbal abuse of staff and lack of good fit. The patient (or the patient's legal representative) has the right to terminate treatment at
his/her discretion. Upon either party's decision to terminate the relationship, the provider will continue emergency care for at least 30 days and recommend more appropriate resources.

g. *LEGAL AND COURT-RELATED MATTERS:* Dr. Mansoor and the providers with San Antonio Family Psychiatry do not take part in court-related matters, such as divorce or child support cases. However, if court-related work is needed, the practices' cost related to that work is the sole responsibility of the patient and/or their responsible party. These matters include but are not limited to preparation, communication with involved parties, depositions, testimony, standby efforts, attorney fees, and other costs incurred as a direct result of the matter.

h. *EDUCATION:* San Antonio Family Psychiatry is also a teaching site. You may be asked to allow students to join your session.

i. *COLLECTION AGENCY:* In the event of a delinquent account balance, **I** will be responsible for all collection fees assessed by the collection agency onto the account.

j. *CONSENT TO TREATMENT:* **I** authorize and request my provider to carry out evaluations and treatment plans for myself, my minor child or legal ward. Paperwork will be needed for any guardianship. I understand that the plan will be explained and is subject to my agreement.

_____

Patient Name Patient Authorized Representative Signature Date

SAN ANTONIO
Family Psychiatry

Release of Patient Information **Date: _____/_____/_____**

Patient Name: _____ Date of Birth: _____

I authorize San Antonio Family Psychiatry to:

- Release to ☐ Receive from ☐ (Check one or both)

Name or Entity: _____

Address: _____

Phone: _____

Fax: _____

Reason for release of patient information: ☐ Medical Records ☐ Coordination of Care ☐ Change Providers

Other: _____

_____

Begin Request Date _____/_____/___ End Request Date _____/____/____

The date, extent or condition upon which this authorization expires is to not exceed 12 months, unless indicated above. I understand I may recant this authorization at any time by written notice.

I understand that this authorization may include information regarding services and treatment received by San Antonio Family Psychiatry and staff, including treatment and testing for drug or alcohol abuse. This authorization is valid for the dates listed above unless otherwise indicated. I hereby release San Antonio Family Psychiatry and its personnel from all legal responsibility that may arise from the act that I have authorized above. San Antonio Family Psychiatry is not responsible for completeness, legibility or omissions used by the copying of any medical records from another institution.

_____

Signature of patient or Legal Ward

_____

Printed Legal Ward

SAN ANTONIO Family Psychiatry

Credit Card Authorization Form

Cardholder Name:_____

Billing Address:_____

Credit Card Type: Visa___ Mastercard__ AMEX___

Credit Card Number:

_____

Expiration Date: _____

Card Verification Number (CVV) _____

I authorize SAFP to charge my credit card for all charges and fees associated with appointments, letters and paperwork, late cancellations and no show of appointments. I understand that if I do not cancel an appointment 24 hours prior to the scheduled appointment my card will be charged and the money will not be refunded.

Date: _____

Patient Name: _____

SAN ANTONIO Family Psychiatry

Patient Clinical Information Date: _____

Full Name: _____

Date of Birth: ____ / ____ / _____ Phone Number: _____

Medication & Allergy Information

Current Medications

List all prescription medications, over-the-counter medications, vitamins, and supplements.

_____

Medication Allergies / Reactions

_____

Other Allergies

☐ No Known Allergies

Allergy	Reaction
Food: _____	_____
Environmental: _____	_____
Latex: _____	_____
Other: _____	_____

Past Psychiatric History

Check all conditions that apply:

☐ Anxiety
☐ Bipolar Disorder
☐ Schizophrenia
☐ Panic Disorder
☐ Substance Use Disorder
☐ Depression
☐ ADHD
☐ PTSD
☐ OCD

SAN ANTONIO
Family Psychiatry

Medical History

Check all conditions that apply:
☐ Hypertension
☐ Diabetes
☐ Thyroid Disease
☐ Seizures
☐ Heart Disease
☐ Asthma
☐ Chronic Pain
☐ Migraines
☐ Sleep Apnea
☐ Other: _____

Additional Medical Conditions / Notes:

Family History

Please indicate if any blood relatives have a history of the following:

Condition	Relation
Depression	
Anxiety	
Bipolar Disorder	
Schizophrenia	
ADHD	
Substance Abuse	
Suicide Attempts	
☐ Diabetes	
☐ Heart Disease	
Other: _____	

Additional Information:

Tobacco Use

☐ Never ☐ Former ☐ Current

Details: _____

Alcohol Use

☐ None ☐ Occasional ☐ Regular

Details: _____

Recreational Drug Use

☐ No
☐ Yes

Details: _____

Exercise

☐ Regular
☐ Occasional
☐ None

Legal History

☐ None

☐ Yes – Please describe any history of arrests, charges, convictions, probation, parole, incarceration, pending legal matters, court involvement, custody disputes, or other relevant legal concerns, including dates and outcomes when applicable:

_____

_____

History of Abuse or Trauma

☐ No
☐ Yes (Physical-Emotional-Sexual)

Please Explain (optional):

_____

_____

SAN ANTONIO
Family Psychiatry

Surgical History

Surgery / Procedure	Date	Hospital / Location

Hospitalizations / Procedures

Psychiatric Hospitalizations

- Psychiatric Hospitalizations? Yes No
  If yes, how long? _____
  Location_____

- Past Diagnosis? Yes No- If yes what?
  _____

- Prior Psychiatric Medications that failed:
  _____
  _____

- Suicide Attempts? Yes No
  If yes when? _____

- Are you in or have been in therapy?
  If yes please list Name, frequency of visits and start/end date or present dates.
  _____

SAN ANTONIO
Family Psychiatry

Social History

Marital Status

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Partnered

Living Situation

☐ Alone
☐ With Family
☐ With Partner/Spouse
☐ Other: _____

Employment / Education

Occupation or School: _____

Additional Comments or Concerns

SAN ANTONIO
Family Psychiatry

MEDICATIONS - CURRENT and PAST MEDICATIONS

List ALL PAST MEDICATIONS that you have taken: Circle One

	Medication Have you ever taken any of these medications	Dose	When & Why Stooped		Medication Have you ever taken any of these medications	Dose	When & Why Stopped
Now Past	Ritalin/Methylin			Now Past	Abilifi		
Now Past	Metadate			Now Past	Aristada or Maintena		
Now Past	Mydayis			Now Past	Rexulti		
Now Past	Aptensio			Now Past	Geodon		
Now Past	Concerta			Now Past	Risperdal/Invega		
Now Past	Focalin (or XR)			Now Past	Zyprexa		
Now Past	Dayårana			Now Past	Seroquel (or XR)		
Now Past	Adderall (or			Now Past	Saphris		
Now Past	Vyvanse			Now Past	Fanapt		
Now Past	Other stimulant			Now Past	Latuda		
Now Past	Strattera			Now Past	Vraylar		
Now Past	Qelbree			Now Past	Caplyta		
Now Past	Clonidine			Now Past	Clozapine		
Now Past	Guanfacine			Now Past	Lithium		
Now Past	Prozac			Now Past	Depa!cte		
Now Past	Zoloft			Now Past	Tegretol (Carbamazepine)		
Now Past	Paxil			Now Past	Trileptal		
Now Past	Luvox			Now Past	Lamictal (lamotrigine)		
Now Past	Celexa			Now Past	Topamax		
Now Past	Lexapro			Now Past	Valium (Diazepam)		
Now Past	Effexor XR			Now Past	(Alprazolam)		
Now Past	Pristiq			Now Past	Ativan (Lorazepam)		
Now Past	Cymbalta			Now Past	Klonopin (Clonazepam)		
Now Past	Wellbutrin			Now Past	Lyrica		
Now Past	Remeron			Now Past	Neurontin		
Now Past	Buspirone			Now Past	Hydroxyzine		
Now Past	Trintellix			Now Past	Ambien (or CR)		
Now Past	Viibryd			Now Past	Lunesta		
Now Past	Fetzima			Now Past	Temazepam		
Now Past	Nefazodone			Now Past	Sonata		
Now Past	Amitriptyline			Now Past	Trazodone		
Now Past	Imipramine			Now Past	Rozerem		
Now Past	EMSAM			Now Past	Melatonin		
Now Past	Nardil			Now Past	Benadryl (antihistamine)		
Now Past	Pamate			Now Past	Other OTC sleep aid		
Now Past	Ketamine			Now Past	Buprenorphine		
Now Past	Provigil/Nuvigil			Now Past	Antabuse (disulfiram)		
Now Past	Aricept (donepezil)			Now Past	Campra(acamprosate)		
Now Past	Namenda (memantine)			Now Past	Naltrexone (oral or injectable		