STONE OAK CHILD AND ADOLESCENT PSYCHIATRY

M. Rao, M.D. Board Certified General Psychiatry * Board Certified Child and Adolescent Psychiatry

Date: _____

Patient Name: _____

Date of Birth: _____ Sex: [ ]Female [ ]Male

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell: _____

Pharmacy. _____ Phone Number: _____

Referred By: _____ Phone Number: _____

Insured's Employer: _____ Insured's Occupation: _____

Employer Address: _____

City/State: _____ Zip: _____ Employer's Phone: _____

(If Applicable) Name of Spouse _____

PLEASE CIRCLE REASON FOR VISIT:

Anxiety Depression Trauma/Abuse Substance Abuse ADD/ADHD

Insurance Information

Insurance Company _____

Insured Name_____

Insured D.O.B_____ Relationship to patient_____

Insurance Company Address _____

City/State_____ Zip _____

Policy ID Number _____ Group Number_____

Insurance Phone Number _____

I, the undersigned, certify that all information listed above is current and correct. I or dependent have insurance coverage as indicated above and assign directly to M. Rao MD all insurance benefits.

I understand that I am financially liable for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorized the use of the signature on all insurance submissions.

X_____ _____ _____

Patient/Guardian Signature Relationship Date

ACKNOWLEDGMENT OF PRIVACY RIGHTS

The Health Insurance Portability & Accountability Act (HIPAA) restricts us from releasing any information without your written permission. I acknowledge that I have been given the opportunity to read the HIPAA Privacy Notice and have been provided a copy of the same. I hereby consent to medical treatment by Stone Oak Psychiatry for myself/minor child and understand that this office is committed to protecting all medical information.

I hereby authorize messages to be left on a voice mail system, answering machine or via text. Please indicate the number(s) our staff can utilize to leave a message for you:

1)_____ 2)_____ 3)_____

_____ _____

Patient/Legal Guardian Signature Witness

_____ _____

Printed Name Printed Name

_____ _____

Date Date

OFFICE POLICIES

- Office hours are 9:00am-5:00pm Monday-Thursday and 9:00am-3:30pm on Fridays. If you are experiencing an emergency situation please call 911 or go to the nearest Emergency Room.

- Please be advised that Dr. Rao has enforced a new patient deposit. What this means is, when scheduling a new patient appointment we are requiring a $200.00 new patient deposit to secure the initial psychiatric evaluation. The $200.00 deposit is refundable at the time of the new patient appointment less the new patient appointment fee. (amount due at the time of service) ****THE NEW PATIENT DEPOSIT IS NON REFUNDABLE IN THE EVENT THE NEW PATIENT APPOINTMENT IS NOT CANCELED WITHIN 48 HOURS.**

- Please leave all possible information with the answering service regarding your telephone message this will assist the doctor in helping you as quick as possible. Missed calls are answered within 24 hours.

- Returned calls will be made as quickly as possible, and in the order that they are received. Numerous calls to the office **will not** prompt faster response. Please remember, the doctor is assisting patients who are in the office for their appointments at the time of your telephone call.

- **It is the patient's responsibility to pay for any charges that are denied by the insurance company. Patients are to notify office at least a week prior to appointment of any change in insurance coverage. If patient fails to inform office of change prior to appointment patient will be responsible for the cost of visit. Patient account will be credited after insurance pays. If your insurance company has not paid your account in full within 60 days, any unpaid balance will be your responsibility.**

- Please remember the date and the time of your follow up appointments and do not rely on the office to call you for a reminder as this is a courtesy service.

- An appointment must be scheduled to see the doctor for any reason. Each patient will receive the best possible care; therefore, we do not see patients on a walk-in basis.

- **A 24 hour notice cancellation for your appointment time excluding weekends and a holiday is required to avoid a $120.00 charge for any missed appointments. This allows enough time to make your reserved slot available to another patient.**

- Every patient will receive the best possible care. We will try to follow the schedule as closely as possible. Thank you for your patience.

- Thank you for not bringing food or drinks into our waiting area. If children must be brought with you to your appointment, please be respectful of property and other visitors.

- Verbal and physical abuse to the doctor or our staff will not be tolerated under any circumstances. All threats are taken very seriously, and a report will be filed with the San Antonio Police Department.

- If you request to speak to the doctor and the discussion is more than 15 minutes there will be a $25.00 fee for service provided.

- Returned checks will incur a $35.00 fee.

Prescription Refill Policy

- We strive to fill your medication at your appointment and will provide you with refills until your next appointment.
- All schedule II medications such as Ritalin, Adderall, and Concerta etc. must be picked up in person.
- If your prescription is not filled within the 21 day deadline, or if the prescription is lost, there will be a $25.00 charge to rewrite the prescription.
- **A minimum of one week is required to process your prescription refill request. Please call our office to request your medication at (210) 403-2074**

Medical Records Policy

- We are happy to provide you with a copy of your medical records. You must first provide a signed release of information. The fee for medical records is $35.00

- Any additional paperwork (forms/letters needed for school/work) will incur a $35.00 charge

- Dr. Rao **does not** provide Disability Paperwork Services

Thank you for choosing Stone Oak Psychiatry
Mrudula Rao, M.D.

_____ _____
Patient/Guardians Signature Date

_____ _____
Witness

Termination Policy

1. If there has been no office visit by the patient for more than 6 months, we will consider the patient's record closed and the doctor-patient relationship terminated. If you desire to re-open your record after this time, you will need to contact our office. However, your case may require a re-evaluation along with any appropriate fees and waiting times.

2. Patients are free to terminate their care at Stone Oak Child and Adolescent Psychiatry at any time and for any reason by notifying their provider.

3. Patients that are disrespectful and verbally abusive towards the Doctor, Staff, or other patients in the waiting room will not be tolerated and will be terminated from the clinic services.

4. Stone Oak Child and Adolescent Psychiatry will exercise the right to terminate services after:
    - Three no shows
    - Three late cancellations (late cancellations are appointments that are not canceled within 24 hours of appointment time).
    - Three rescheduled appointments

5. If you are still in need of behavioral health services, you may go to the nearest emergency room. You may also contact one of the following psychiatric hospitals: Laurel Ridge (210) 491-9400, Methodist Hospital (210) 575-0500, and Nix Hospital (210) 341-2633. If you are without health insurance, you may contact The Center for Health Care Services (210) 261-1000.

I understand the Termination Policy

Patient/Guardian Signature_____Date_____