Vanessa L. Vela, M.D.
109 Falls Court, Suite 600
Boerne, TX 78006

Phone: 830-428-0944
Fax: 830-331-9922

Date _____

Patient's Name:_____ Gender: _____Male/Female_____

Date of Birth:_____ Age:_____ Patient's Social Security #:_____

Address:_____ City, State, Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Occupation:_____Employer:_____

(If applicable) Spouse's Name: _____

(If applicable) School:_____ Grade:_____ School District:_____

Mother's Name:_____ Employer:_____ Phone:_____
(IF PATIENT IS A CHILD/MINOR)
Father's Name:_____ Employer:_____ Phone:_____
(IF PATIENT IS A CHILD/MINOR)

Patient Lives With:_____

Who referred you to my office?_____ Patient's Primary Care Doctor:_____

(If applicable) Name of Psychologist or Psychotherapist:_____

Preferred Pharmacy, Phone Number, & Zip Code:_____

***Emergency Contact**:_____ Phone:_____*

Your appointment date and time is your responsibility to remember. As a **courtesy**, we **try** our best to call but circumstances do not always allow us the time to make this courtesy call, but if we can…

May we leave a voice message? _____ Yes _____ No
What phone number may we leave a message? _____ Cell _____ Home _____ Work

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LEGAL GUARDIAN INFORMATION (IF NOT PARENT)

Name:_____ Relationship to Patient:_____
Address:_____
Home Phone:_____ Cell Phone:_____Wk: Phone:_____

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IMPORTANT PRACTICE INFORMATION

EMPHASIS ON HEALTH AND HEALING: I am happy to answer your questions regarding the importance of diet, exercise, and alternative treatments. You deserve a doctor that will keep in mind side effects, and I want you to let me know if the medications I am prescribing are hindering your daily activities in any way.

Psychiatric medication alone is not always the answer for depression, anxiety, or other mental health issues. I will encourage you to utilize other adjunctive treatments to help you with your presenting issues when appropriate.

CONFIDENTIALITY: Your privacy is extremely important. All protected health information (PHI) will be held in the strictest confidence. A copy of my privacy practices is included in this paperwork. Medical records/PHI may be released regardless of consent in the following circumstances:

(1) According to state and local laws I must report to the appropriate agencies all cases of physical or sexual abuse or neglect of minors or the elderly,
(2) I must report to the appropriate agency all cases in which there is a danger to self or others,
(3) When authorized to process medical claims and payment of benefits,
(4) In the event you are in need of emergency services,
(5) If you become involved in specific kinds of legal proceedings, the court may subpoena records.

EMERGENCY SERVICES: If you are having an emergency, dial 911 or proceed to the nearest emergency room. If you have after hour questions or feel you need to reach me after business hours, you can call the office to hear a recorded message with instructions on how to reach me. You will be charged an after hours call fee.

MEDICATION REFILLS: Please allow 120 hours (5 days) for refills. Please have your pharmacy FAX non-stimulant refill requests—this is clearly the most expeditious way of my getting your medications taken care of. I may deny your refill requests if you do not follow up as instructed.

Patients taking C-2 drugs (stimulants) requiring special prescriptions will be seen no less than every three months. Patients who do not follow up as instructed <u>WILL NOT</u> receive prescriptions for this class of medication.

MISUSE OF MEDICATIONS OR PRESCRIPTIONS: I will terminate care of a patient who misuses any medication that I prescribe. This includes, but is not limited to, taking medications for intoxication purposes or attempts to harm oneself. If you require stimulant medication, I will ask you to sign a separate form with my policies for those.

<u>Any</u> attempt to use my prescriptions or information pertaining to prescriptions to obtain medication/drugs for sale or misuse will result in both termination of care as well as criminal prosecution.

HOSPITALIZATION: I will work with you to help solve any problem with treatment—from medication problems to weekend appointments. It is very, very rare that I recommend hospitalization to help someone keep him or herself safe. This is one of the only times where I will be very strict and require that a patient follows my recommendation. Therefore, if a patient elects not to follow medical advice regarding the need for Psychiatric Hospitalization, I will recommend that they seek care with another physician. Again, I only recommend hospitalization if I truly believe the patient's life is in danger without it.

_____ _____
Patient's/ Guardian's Signature Date

_____ _____
Witness Date

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FEE SCHEDULE

$300.00	ADULT DIAGNOSTIC INTERVIEW (1HOUR)
$150.00	ADULT FOLLOW-UP (20-30 MINUTES)
$360.00	CHILD DIAGNOSTIC INTERVIEW (1.5 HOURS)
$150.00	CHILD FOLLOW-UP (20-30 MINUTES)
$150.00	**NO SHOW FEE FOR APPOINTMENTS WITHOUT 48 HOUR NOTICE**
$150.00	RESCHEDULE/CANCELLATION WITHOUT 48 HOURS NOTICE

**New patient appointments that are not attended and not cancelled without a 48-hour notice (excluding weekend hours) will not be rescheduled. **

Phone Contacts

Phone conversations may occur to answer **urgent** questions or provide needed stabilization or advice. Every contact you make with your provider requires additional documentation. As such, your provider charges a fee in accordance with phone consults. **If you have a concern that's not urgent in nature, we encourage you to schedule an appointment to speak with your doctor.**

Phone contacts **ARE NOT** covered by insurance and are the patient's sole responsibility.

$60.00	PHONE CONSULTATION-1-15 MINUTES
$150.00	PHONE CONSULTATION 16-30 MINUTES
$150.00 PER 20 MINUTES	AFTER HOURS/HOLIDAY PHONE CONSULTATION

Forms, Letters and Documentation

Any additional paperwork, letters or forms not related specifically related to intra-office care will be subject to a fee based upon the complexity and time needed to complete the necessary documentation. **Payment of this fee will need to be completed prior to release of the paperwork, forms or letters.**

$35.00 (PER 15 MINUTES)	WRITTEN NOTES TO BE COMPLETED BY THE PHYSICIAN FOR NON-LEGAL PURPOSES.
$35.00	***2ND STIMULANT PRESCRIPTION OR ANY PRESCRIPTION WHICH REQUIRES AN ADDITIONAL PRESCRIPTION BY THE PHYSICIAN***
$300.00 (PER HOUR)	REVIEWS OF RECORDS FOR COURT AND OTHER LEGAL PURPOSES AND REQUIRES A **$1500.00 RETAINER** TO BE PAID PRIOR TO THESE SERVICES.
$400.00 (PER HOUR)	*COURT TESTIMONY-TO INCLUDE TRAVEL TIME IF WITHIN 50 MILES, STAND-BY EFFORTS, WRITTEN AND ORAL CORRESPONDENCE WITH LEGAL REPRESENTATIVE, AND ANY OTHER WORK RELATED TO THE CASE. REQUIRES **$5000.00 RETAINER** TO BE PAID PRIOR TO THESE SERVICES.*

Travel time beyond 50 miles will require the $400.00 hourly fee billed at 8 hours per day regardless of the amount of time spent on the case ~ In addition to all expenses for purposes of travel, lodging and meals, a $7000.00 retainer fee is due prior to travel.

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Missed Appointments: *If you need to cancel an appointment, please give 48 hours notice. If 48-hour notice is not given, you will be charged the full appointment fee. Insurance companies will not reimburse for this charge.*

Termination of Doctor-Patient relationship: failure to follow the prescribed treatment plan, failure to keep routine appointments, failure to meet financial obligations may result in termination of services. Please discuss other reasons for referral and termination with your doctor if you have questions. Medical records will be provided to your physician upon receipt of signed medical release form.

Patient's/Guardian's Signature: _____ Date:_____

CONSENT FOR MEDICAL TREATMENT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING.

I (for) the undersigned patient, do hereby voluntarily consent to such treatment involving routine diagnostic procedures and medical treatments as considered necessary by Vanessa L. Vela, M.D. and her assistants, or her designees. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered.

I further authorize and instruct Vanessa L. Vela, M.D. to release to the persons or organizations herein specified, or to any other agency concerned with the payment of my charges or further treatment, any and all medical information, including copies or records requested or required by such person or organizations.

I understand that any of the above requested information might include results of Human Immunodeficiency Virus (HIV) test if any were performed.

Furthermore, I understand that any of the above requested information might include results of alcohol/drug (substance) abuse screening and/or diagnosis and treatment of psychiatric disorders.

_____ _____
Patient's/ Guardian's Signature Date

_____ _____
Witness Date

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FINANCIAL POLICIES

PAYMENT OF FEES: Payment is expected at each visit. I am only contracted with Beacon Behavioral Health and Blue Cross Blue Shield PPO Insurance. This means that if you have any other insurance and you would like to use your insurance benefits, filing appropriate paperwork is your responsibility. We are happy to provide you with detailed statements of your account to help you do so. I do not participate in Medicaid or Medicare; therefore, it will not be covered under your benefits. You will have to sign a contract stating you understand I am not a participating provider with Medicaid or Medicare before your first visit or as soon as you become involved in the program.

PAYMENT FOR SERVICES: Clients are expected to pay for services at the time they are provided. Payment may be made by cash, check, Visa, Master Card or Discover. Clients are responsible for all fees even if planning to bill an insurance company for reimbursement.

CANCELLATION POLICY: Your time is extremely valuable. I try to keep customer service high by not "overbooking." This allows me to run on time or very close to it. The trade off for this service is that I charge a missed appointment fee.

IF MY MISSED APPOINTMENT FEE POLICY IS NOT ACCEPTABLE, PLEASE LET US KNOW TODAY SO THAT YOU MAY FIND A DOCTOR WHOSE FINANCIAL POLICIES ARE BETTER SUITED TO YOUR NEEDS.

*****A credit card number is required to hold your first (new patient) appointment. A $100 fee will be charged to this card if you miss your first appointment without 48 hours notice of cancellation.**

*****After your first appointment, we will destroy your credit card information*****

*****You will be charged the full appointment fee for missing a follow up appointment unless you contact my office 48 hours in advance. Monday appointments must be cancelled by Friday at 12:00 p.m.**

Missed appointment fees will be waived for medical emergencies if we are called prior to or the same day of the appointment. Other situations (work problems, forgetting the appointment, being in jail or intoxicated, etc.) will result in being charged the fee. If you do not want to pay your missed appointment fee, please let me know immediately, and I will understand that you need to find a doctor whose financial policies better suit you.

PAYMENT FOR MISSING YOUR FIRST APPOINTMENT WILL BE CHARGED TO YOUR CREDIT CARD IF YOU DO NOT CANCEL 48 HOURS PRIOR.

All insurance co-payments, co-insurance payments, deductibles, private pay payments, or any other payments must be paid in full before your next follow-up appointment. We accept cash, check, Visa, Master Card and Discover. A $35.00 fee will be charged for returned checks. You must call the office to make other payment arrangements for a returned check.

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DISABILITY PAPERWORK: I do not charge anything to fill out FMLA paperwork. However, other disability paperwork (often involving some research) is significantly time-consuming. I am happy to complete these tasks but I do bill for them at my standard rate. Please review the section regarding forms, letters and documentation. These charges, like patient fees, are NOT billed to your insurance company—they are your responsibility.

TELEPHONE/ LEGAL CONSULTATION: I encourage you to call if you have questions about your medications or other aspects of your care. For the overwhelming majority of phone calls like routine questions about medication, I do not charge. However, occasionally someone will want me to talk on the phone for extended periods with family members or employers, or their attorney. Please review the financial fee schedule on the second page of this document. Again, these charges are NOT billed to your insurance company—they are your responsibility. I will always inform a patient that a telephone call or a personal meeting is billable time prior to any consultation.

TELEPHONE APPOINTMENTS: When I have a phone session with a patient, my standard appointment fees will apply—not the above mentioned telephone consultation rate.

COURT COSTS: I am not a Forensic Psychiatrist. It is very disruptive to the office routine and unfair to other patients when I am ordered to testify in proceedings. I do not want to be involved in any legal proceedings, therefore, if you are considering involving me in any legal procedures, please be sure to review the costs associated with court fees.

Unpaid fees, of any type, may be forwarded to a collections agency.

My signature below indicates that I have read and agree with the above Financial Policies.

_____ _____

Signature of patient (or responsible party) Date

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BEACON BEHAVIORAL HEALTH OR BLUE CROSS BLUE SHIELD INSURANCE INFORMATION

Only if you have Beacon or BCBSTx PPO do you need to fill out the following information. Otherwise, you are a private pay patient.

Insurance Company:_____ Behavior Health Phone:_____

Member ID:_____ Group No. :_____

Policy Holder:_____

Sex: _____ Male/Female _____ Date of Birth:_____

Policy Holder's Social Security No.:_____

Relationship to Patient:_____

I hereby assign, transfer, and set over to Vanessa L. Vela, M.D. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. **I understand that I am financially responsible for all charges whether or not they are covered by insurance and I must pay the deductible, co-pay or co-insurance amount at the time of the visit.**

_____ _____

Patient Signature (or responsible party) Date Signed

Private Pay Acknowledgement

I acknowledge that I am requesting services from Vanessa L. Vela, M.D. on a private basis. I am acknowledging that I do not currently have insurance coverage with Beacon Behavioral Health or Blue Cross Blue Shield or if I do, I am choosing not to claim these services. I understand that if I do choose to use my insurance coverage in the future that services previously rendered will not be eligible for coverage or back billing.

*Date:*_____

*Patient's/Guardian's Printed Name:*_____

*Patient's/Guardian's Signature:*_____

Witness Printed Name: _____

Witness Signature: _____

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Notice of Privacy Practices

Effective Date: April 12, 2013

In accordance with the Health Insurance Portability and Accountability Act I am required to provide you with this information regarding my responsibilities to you regarding how your psychological and medical information may be used and disclosed and how you might get access to this information. It is intended to clarify these responsibilities and right. Please ask if you have any questions.

The notice of Privacy Practices has been provided to me prior to my signing this consent. The Notice includes a complete description of the uses and/or disclosure of my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in the treatment.
- Obtained payment for that treatment.
- Conduct normal healthcare operations.

The practice explained to me that the Notice will be available to me in the future at my request and explained my right to obtain a copy of the Notice prior to signing this consent.
The practice reserves the right to change its privacy practices that are described in its Notice of Privacy Practices.
I understand and consent to the following appointment reminders that will be used by practice:

- Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
- The Practice may use and/or disclose my PHI, which includes information about my health or condition and the treatment provided to me, in order for the practice to treat me and obtain payment for that treatment and as necessary for the Practice to conduct its specific health care operations.
- I understand that I may request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to the requested restriction, then the restriction is binding on the Practice.
- I understand that this consent is valid for 2 years. I further understand that I have the right to revoke this consent, in writing, at any time for all further transactions, with the understanding that any such revocation shall apply to the extent that the practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the practice has the right to refuse to treat me.
- I understand that if I do not sign this consent evidencing my consent to the uses and disclosures described to me above and contained in the Notice, then the Practice will not treat me.
- By signing this form, you acknowledge that this medical practice has given you a copy of its Notice of Privacy Practices. This notice explained how your health information will be handled. HIPPA, the new Federal Law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. The Practice of Dr. Vanessa L. Vela has given me the opportunity to ask any questions about this notice and my questions have been answered.

Patient's/Guardian's Signature Date Signed

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******Provider use only******

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below:

Patient was given the notice: _____yes _____no

Reason signature was not obtained: _____

Staff Signature *Date*

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS, SCHOOLS & PRIMARY CARE PHYSICIANS

Patient:_____ Date:_____

DOB:_____ SSN: _____

I request and authorize the office of Dr. Vanessa L. Vela, M.D. to release healthcare information for the patient named above, to the following: Family, Friends, School and/or Primary Care Physician as listed below:

Name:_____ Relationship: _____

Name:_____ Relationship: _____

School Name: _____

Primary Care Physician and phone: _____

Previous Psychiatrist and phone number: _____

Therapist/Counselor and phone number: _____

This release and authorization applies to the following *(check all that apply):*

____ All health care information
____ Only dates of service from _____ to _____
____ Only information pertaining to the treatment of _____
____ Mental Health Information, Mental Retardation Information
____ Alcohol/Drug (substance) information
____ HIV/AIDS information
____ Other _____

*I request that information **NOT** be released to the individuals listed below:*

Name:_____Relationship: _____

Name: _____Relationship: _____

*This authorization expires when revoked by me **IN WRITING** whichever occurs first. If I revoke this authorization, I do understand that the doctors named in reliance on my original authorization may have already released information.*

_____ _____ _____
Patient's/Guardian's Signature Relationship Date