BLUEBONNET HILL
PSYCHIATRY

a partner of
Amarillo Medical Specialists

PATIENT INFORMATION		
First Name:	Middle Initial:	Last Name:
Is this your legal name? YES / NO	If not, what is your legal name?	
Are you your own legal guardian? YES / NO	If not, who is your legal guardian?	
Gender:	Preferred Pronouns:	
Date of Birth:	Social Security #:	
Race/Ethnicity:		
Mailing Address:		
Home Phone:	Cell Phone:	
Email:		
Would you like to sign up for the patient portal so you can view your lab results? YES/NO		

INSURANCE INFORMATION	
Primary Insurance: Policy Holder Information	**Secondary Insurance: Policy Holder Information:**
Policy Holder Name:	Policy Holder Name:
Relationship to Patient:	Relationship to Patient:
Date of Birth:	Date of Birth:
Social Security #:	Social Security #:
Insurance Company:	Insurance Company:
Ins. Co. Address:	Ins. Co. Address:
Group # / Contract #:	Group # / Contract #:
Employee/Cert #: Deductible: $	Employee/Cert #: Deductible: $
Financial Responsible Party Complete this section only if the information is different from the Patient Information Section	
Name:	Relationship to Patient:
Date of Birth:	Social Security #:
Mailing Address:	City/State/Zip:
Employer:	Phone:

EMERGENCY CONTACT INFORMATION	
PARENT/LEGAL GUARDIAN CONTACT INFORMATION (PATIENTS 18 AND YOUNGER)	**EMERGENCY CONTACT INFORMATION (PATIENTS 18 AND OVER)**
Parent/Guardian Name:	Emergency Contact Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Parent Home Phone:	Contact Home Phone:
Parent Cell Phone:	Contact Cell Phone:

PREFERRED PHARMACY CONTACT INFORMATION	
PREFERRED LOCAL PHARMACY:	**MAIL ORDER PHARMACY:**
Name of Pharmacy:	Name of Pharmacy:
Location:	Location:
City/State/Zip:	City/State/Zip:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

Patient/Guardian Signature: _____ Date: _____

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TREATMENT CONTRACT & OFFICE POLICIES

We respect your time and make every effort to stay on schedule. If we are running late, we may be dealing with an emergency. Please be patient and know that we are trying to provide the best care for you and our other patients.

Patient/Guardian Initials: _____

We respect your privacy and the privacy of our other patients. Therefore, we ask that **only the patient and his/her parent or guardian** be present for his/her appointment with Dr. Grant. If multiple family members are seeing Dr. Grant on the same day, please know that family members will be asked to wait outside until their scheduled appointment time. Please arrange for child care accordingly.

Patient/Guardian Initials: _____

Dr. Grant requires that you see her **at least every 3 months** (either in person or via telehealth) so that she may monitor your mood, response to psychotropic medication(s), and any adverse side effects. You must present **in person at least once a year**.

Patient/Guardian Initials: _____

All medications can cause side effects. Some psychotropic medications can increase your risk for metabolic syndrome. Others can increase your risk for thyroid dysfunction, kidney disease, liver damage, and blood disorders. **If one of these medications is indicated in your treatment, Dr. Grant will order baseline labs and then routine lab work during your course of treatment.** In order to monitor for any adverse effects, it is crucial that you comply with recommended lab work. **If you are unable/unwilling to comply with recommended lab work, please let Dr. Grant know immediately** so that she may discuss alternative treatment options with you.

Patient/Guardian Initials: _____

Dr. Grant specializes in mental health. She **does not** provide primary care nor does she write or refill prescriptions for non-psychotropic medications. Therefore, she expects you to see your primary care physician (PCP) **at least yearly** for your annual physical/check-up.

Patient/Guardian Initials: _____

If you are receiving psychotropic medications from another physician without our knowledge, you will be discharged from our clinic. This is known as "doctor shopping" and will not be tolerated.

Patient/Guardian Initials: _____

You may have **one pharmacy** on file with our clinic. We will not call in medications to multiple pharmacies. If you switch pharmacies, you need to notify us and your previous pharmacy of this change.

Patient/Guardian Initials: _____

Dr. Grant teaches medical and nurse practitioner **students**. If you choose to receive care at this clinic, you are agreeing to students being part of your treatment team. Students have received HIPAA training and understand that all patient information is confidential.

Patient/Guardian Initials: _____

All copays, co-insurance, and deductible amounts will be collected prior to your scheduled appointment. We accept checks, cash, and credit cards.

Patient/Guardian Initials: _____

Please be courteous to all staff. Inappropriate or threatening behavior is not tolerated and will lead to discharge from our clinic.

Patient/Guardian Initials: _____

Dr. Grant does not accept any social media requests or messages sent via social media. Please contact the office with any questions/concerns.

Patient/Guardian Initials: _____

CONFIDENTIALITY POLICY

Your care and your medical records are confidential, except in these specific instances:
1. I am required by law to report suspected child/elder/disabled abuse.
2. If you threaten to harm someone, I am required by law to provide information to others in order to protect him/her.
3. If I believe you are in crisis and may harm yourself/someone else, I may call EMS and recommend hospitalization.

Patient/Guardian Initials: _____

LATE POLICY

Please arrive to your scheduled appointment on time. We understand that delays can happen; however, we must try to keep our other patients on time. Therefore, if you arrive late to your appointment, you will be seen for the **remaining time** of your scheduled appointment only.

If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule, and you will be counted as a no show for that appointment.

Patient/Guardian Initials: _____

CANCELLATION / NO SHOW POLICY

We understand there are times when you must miss an appointment due to family/work obligations or emergencies. If you need to cancel or reschedule an appointment, please call us at least 48 hours in advance.

If an appointment is not cancelled at least 48 hours in advance, you will be charged a $50 fee. This fee will not be covered by your insurance company and must be paid prior to rescheduling.

You will be discharged from the clinic if you:
1. **Are consistently late to your appointments.**
2. **No show 2 appointments within a 12 month period.**
3. **Cancel 2 or more consecutive appointments.**
4. **Cancel multiple appointment within a 12 month period.**

Patient/Guardian Initials: _____

TELEHEALTH POLICY

In certain circumstances, Dr. Grant may allow appointments to be done via telehealth. In order to deliver safe and effective care via telehealth, the following expectations must be met.

1. You must be seen **in person** at the clinic **at least annually**.
2. You must be in a **private location** with **adequate internet/phone service** during telehealth visits.
3. You must be stationary (**NO DRIVING**) during your telehealth appointments.
4. You must provide the physical **address** where you are located.
5. You must be **in Texas** during any telehealth appointments with Dr. Grant. If you will not be in Texas at the time of your appointment, please call us at least 48 hours in advance to reschedule your appointment.
6. You must be available during the **entirety** of the telehealth appointment.
7. If you are a minor or you have a **legal guardian**, your parent/guardian/caretaker must be present and available for the duration of the telehealth appointment.
8. You must be **sober** and refrain from using alcohol/illicit substances during the appointment.
9. You must be **dressed appropriately** for a doctor's appointment.
10. If you are having trouble connecting or do not see your doctor online, please call the clinic within the first **5 minutes** of your appointment.
11. The **late and cancellation / no show policies** apply to telehealth appointments.

Patient/Guardian Initials: _____

AFTER HOURS POLICY

This clinic is **not** open after hours. Calls after hours will be answered by an answering service. If the patient is in crisis/there is an emergency, the patient will be directed to call 911 or go to the nearest emergency room.

Patient/Guardian Initials: _____

It is your responsibility to allow sufficient time to refill prescriptions during normal business hours. You will not be able to get refills after hours. If the medication is a non-controlled, you may ask your pharmacy to provide a bridge over the weekend.

Patient/Guardian Initials: _____

No medication changes will be made over the weekend. Calls will be returned within 24-48 hours of the next business day.

Patient/Guardian Initials: _____

CONTROLLED SUBSTANCES POLICY

The Texas Prescription Monitoring Program (PMP) collects and monitors controlled substances prescription data. If Dr. Grant learns that you are not taking your medication as prescribed, or that you are receiving controlled scripts from multiple providers/pharmacies, Dr. Grant will stop prescribing these medications and you may be discharged from the clinic.

Dr. Grant may require you to complete a **urine drug test** before/during treatment with a controlled substance.

Dr. Grant **does not** provide **early refills** on controlled medications. If you are going out of town and need your medication refilled before you leave town, please let us know so that we may coordinate with your pharmacy.

If your medication is **lost or stolen**, you will need to file a police report before we will send a replacement prescription. To file a police report with the Amarillo Police Department, call the Amarillo Emergency Communications Center (AECC) at 806-378-3038.

Patient/Guardian Initials: _____

LABORATORY & RADIOLOGY RESULTS POLICY

Laboratory and radiology results require minimum of **seven (7) days** to be available in our office. This allows time for your physician to review **ALL** results. Our office will call you once your results have been reviewed. If you have not heard from our office after **seven (7) days,** please feel free to contact us. If you have internet access, we encourage you to sign up for the web-based **patient portal**. Once your test results are reviewed, they will be available to view on the patient portal.

Patient/Guardian Initials: _____

FORENSIC / CUSTODY EVALUATIONS POLICY

Dr. Grant serves as a treating psychiatrist. Her role is to help patients express their feelings and how to cope with and respond to the events occurring in their lives. When a treating psychiatrist is asked to weigh in on legal matters, the therapeutic relationships between psychiatrist and patient and between psychiatrist and the patient's loved ones are often compromised. Therefore, Dr. Grant **does not** perform custody evaluations, provide recommendations/reports, or testify about a child's custody. Likewise, she **does not** perform parental fitness evaluations.

Patient/Guardian Initials: _____

EMOTIONAL SUPPORT ANIMAL (ESA) / PSYCHIATRIC SERVICE DOG (PSD) POLICY

While we understand animals can serve as a source of comfort and support, animals can also be a liability. Dr. Grant does not evaluate an animal's behavior or assess an animal's impact on his/her owner. Therefore, she **does not** provide Emotional Support Animal (ESA) or Psychiatric Service Dog (PSD) letters.

Patient/Guardian Initials: _____

MEDICAL MARIJUANA POLICY

Dr. Grant is not registered with the Compassionate Use Registry of Texas (CURT), and she **does not** prescribe medical marijuana.

Patient/Guardian Initials: _____

FMLA / DISABILITY PAPERWORK POLICY

Dr. Grant will only consider completing this paperwork on your behalf if you have been a patient of hers for **at least 6 months**.

Patient/Guardian Initials: _____

I understand and agree to **all** of the above-mentioned policies.

Patient/Guardian Signature: _____ Date: _____

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HEALTH INFORMATION EXCHANGE (HIE)

The Health Information Exchange (HIE) allows health care professionals and patients to access and securely share a patient's medical information electronically. It is a database where records are electronically stored. Doctors can sign into this database and see records from other doctors you have seen in the past.

Only doctors you are currently seeing are allowed to access this database. Emergency rooms in Amarillo are also able to access this database.

This database is Health Insurance Portability and Accountability Act (HIPAA) approved.

I understand and agree to the above-mentioned policies.

Patient/Guardian Signature: _____ Date: _____

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ACKNOWLEDGMENT OF PRIVACY PRACTICES (HIPAA)

Patient Name: _____ Date of Birth: _____

All patient information is confidential and will not be shared without your consent. If you would like us to share your information with a family member/friend, please indicate that below.

1. Please list the family members and/or other persons, if any, whom we may inform about your medical condition (including diagnosis, treatment, payment, and other health care operations):

   _____
   Name & relationship to patient Phone Number

   _____
   Name & relationship to patient Phone Number

2. Please list the family members and/or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

   _____
   Name & relationship to patient Phone Number

   _____
   Name & relationship to patient Phone Number

3. Please list the telephone number(s) where you want to receive calls about your appointments, lab/imaging results, and any additional health care information:

   _____

4. Can confidential messages be left on your answering machine? YES / NO

Please note that while we may ask you from time to time if there have been any changes to this information, **it is your responsibility to update this information as needed**.

By signing below, you acknowledge that you have received this Notice of Privacy Practices **prior** to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as above.

Patient/Guardian Signature: _____ Date: _____

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Other Name(s) Used: _____

Date of Birth: _____ Phone: _____

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

I need my records sent <u>FROM</u>:

Physician/Clinic/Hospital: _____

Address: _____

Phone: _____ Fax: _____

I need my records sent <u>TO</u>:

Physician/Clinic/Hospital: _____

Address: _____

Phone: _____ Fax: _____

I understand that information in my health record includes information about behavioral or mental health services and may include information about treatment for alcohol and drug abuse. It may also include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

Patient/Guardian Signature: _____ Date: _____

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CHIEF COMPLAINT / REASON FOR THE APPOINTMENT Please use the back of this page if necessary.

CURRENT MEDICATIONS Please list ALL the medications you are currently taking, including over the counter medications, vitamins, and supplements. Please use the back of this page if necessary.		
MEDICINE / VITAMIN	**DOSE**	**FREQUENCY**

ALLERGIES Please list any medications or products you have taken which may have caused a **true allergic reaction or undesirable side effects** (hives, itching, rash, difficulty breathing, muscle aches, cough, nausea, etc). Please use the back of this page if necessary.			
NAME OF MEDICATION	**REACTION**	**NAME OF MEDICATION**	**REACTION**

PAST MENTAL HEALTH TREATMENT Please list your previous mental health providers. Please use the back of this page if necessary.		
PSYCHIATRIST / PHYSICIAN / PHYSICIAN ASSISTANT / NURSE PRACTIONER / THERAPIST	**DATES OF TREATMENT**	**MAY WE REQUEST YOUR MEDICAL RECORDS FROM THIS PROVIDER?**
		YES / NO
		YES / NO
		YES / NO

PAST PSYCHIATRIC HOSPITALIZATIONS Please list all previous hospitalizations and residential treatment centers. Please use the back of this page if necessary.			
REASON FOR HOSPITALIZATION	**PLACE OF HOSPITALIZATION**	**DATES OF HOSPITALIZATION**	**MAY WE REQUEST YOUR MEDICAL RECORDS FROM THIS HOSPITAL?**
			YES / NO
			YES / NO
			YES / NO

PAST MEDICAL HISTORY

Please review this sheet and mark any condition you have or have had in the past.

ILLNESS	YES	ILLNESS	YES	ILLNESS	YES
Abnormal heart rhythm		Hepatitis		Seizures	
Alcohol/drug abuse		High blood pressure		Sleep apnea	
Asthma		High cholesterol		Sleep disorder	
Blood disorder		HIV/AIDS		Stroke	
Cancer		Kidney disease		Syncope (fainting)	
Dementia		Liver disease		Thyroid disease	
Diabetes		Lupus		Traumatic brain injury (TBI)	
Headache		Neuropathy			
Heart murmur		Parkinson's disease			

☐ I have reviewed the information on this page, and I have no past medical history to report.

PAST MEDICAL HISTORY **(non-psychiatric conditions)** Please use the back of this page if necessary.		
MEDICAL CONDITION	**YEAR OF DIAGNOSIS**	**PHYSICIAN MONITORING/MANAGING THIS CONDITION**

PAST HOSPITALIZATIONS (for non-psychiatric conditions) Please use the back of this page if necessary.	
REASON FOR HOSPITALIZATION	**DATE OF HOSPITALIZATION**

PAST SURGERIES / SERIOUS ACCIDENTS Please list any surgeries or serious accidents you have had in the past. Please use the back of this page if necessary.			
SURGERY	**YEAR**	**SURGERY**	**YEAR**

FAMILY HISTORY		
FAMILY MEMBER	**MENTAL HEALTH CONDITION(S)** (depression, anxiety, bipolar disorder, schizophrenia, personality disorder, ADHD, autism, substance use, etc.)	**OTHER HEALTH CONDITION(S)** (high blood pressure, heart disease, diabetes, thyroid disease, seizures, stroke, dementia, or cancer, etc.)
GRANDPARENTS		
FATHER		
MOTHER		
AUNT(S)/UNCLE(S)		
BROTHER(S)		
SISTER(S)		
CHILDREN		

SOCIAL HISTORY	
Marital Status:	Sexual orientation:
Do you have children? YES / NO	If yes, how many?
What is your current living situation?	
Who else lives in your home? (Name, Age, Relationship)	
Current employment status:	
Occupation:	Employer:
What is your highest level of education completed?	
Did you serve in the military?	If yes, in what capacity?
Have you ever been arrested/been incarcerated?	If yes, what for?

STRESSORS Please circle any current stressors that may be affecting your mood:	
Marital/relationship conflicts Unemployment Retirement Financial strain Unstable housing Unsafe living environment/neighborhood Death of a loved one Addiction/substance use Health problems/injury Pregnancy Infertility Raising children Sex difficulties Loss/change of faith Sick/elderly relative Separation/divorce of parents	Work/school responsibilities Sports/clubs Problems with peers/friends Bullying Poor body image Moving to a new location Legal problems Domestic violence Trauma/abuse Too many commitments/too busy Other (please explain):

HABITS		
Do you follow a special diet?	YES / NO	If yes, what type:
Do you exercise regularly?	YES / NO	If yes, what type and how often?

Have you ever used / do you currently use tobacco products?	Currently smoking? Yes ☐ No
If yes, how many packs per day?	How many years?
Are you thinking about quitting? ☐ Yes ☐ No	Date you quit smoking?
Do you use snuff or chewing tobacco? ☐ Yes ☐ No	If so, how much?
Do you drink alcohol? YES / NO	If so, what type?
How many drinks in a day?	How many years?
Do you regularly use sleeping pills, tranquilizers, or pain killers?	If yes, which ones?
Do you currently use marijuana, methamphetamine, cocaine, or other "recreational" drugs?	If yes, which ones?
Have you ever received substance abuse treatment? YES / NO	If yes, where and when?
Do you drink caffeinated beverages? YES / NO	If yes, how many daily?
Do you have any drug, nicotine, or alcohol habits that concern you? YES / NO	

GENERAL HISTORY	
Who is your primary care physician (PCP)?	
Do you see your PCP for regular well visits (at least yearly)? YES / NO	When did you last see your PCP?
Do you have regular visits with a dentist (at least yearly)? YES / NO	When did you last see your dentist?
What is your current weight?	Has it changed in the past 6 months? YES / NO
How much? + / -	Intentional? YES / NO
Are you pregnant or trying to get pregnant? YES / NO	Are you currently nursing? YES / NO
How would you rate your health at present? POOR / FAIR / GOOD / EXCELLENT	

PLEASE CHECK ALL THAT CURRENTLY APPLY TO YOU

SKIN:		GASTROINTESTINAL:		MUSCULOSKELETAL:	
Change in skin coloration		Abdominal pain		Back pains	
Recent change in hair distribution		Black stools		Bone pains	
Recurrent itching		Blood in stools		Joint pains	
Recurrent rash or eruptions		Becoming nauseated after meals		Joint stiffness	
HEAD, EARS, NOSE, THROAT:		Change in appetite		Joint swelling	
Bad teeth		Change in bowel habits		Muscle aches	
Deafness		Change in stool color		**NEUROLOGICAL:**	
Dizziness		Constipation		Arm or leg numbness	
Headaches more than once a week		Diarrhea		Arm or leg weakness	
Nasal discharge/sinus trouble		Getting full quicker than usual		Change in speech	
Nosebleeds		Have pain when moving bowel		Drowsiness	
Ringing in ears		Have you ever had an ulcer		Seizures	
Trouble/pain when swallowing water/food		Heartburn		Tremors	
Visual disturbances (double vision, blurred vision, or loss of vision, etc)		Hemorrhoids		**PSYCHIATRIC:**	
RESPIRATORY:		Increased abdominal gas		Difficulty making decisions	
Chest colds more than twice/week		Intolerance to certain foods		Ever considered or attempted suicide	
Coughing up blood		Mucus or pus in stool		Hard to concentrate or remember	
Difficulty Breathing		Nausea and/or vomiting		Often cry for no reason	
Exposure to TB		Rectal pain		Often lonely or depressed	
Night sweats		Vomiting up blood		Tired most of the time	
Previous abnormal chest x–rays		Yellow jaundice		Trouble sleeping	
Recurrent cough		**GENITOURINARY:**		**HEMATOLOGIC:**	
Shortness of breath when walking		Brown, bloody, or cloudy urine		Anemia	
Wheezing/Asthma		Burning when you urinate		Blood transfusions	
CARDIAC:		Constant feeling you have to urinate		Lymph gland swelling	
Ankles and feet swell		Ever had a sexually transmitted disease		Swelling in armpits or groin	
Been told you have a heart murmur		Frequency in urination		Tendency to bruise or bleed easily	
Been told your heart is enlarged		Losing urine when you cough, sneeze or lift heavy objects			
Blacked out and fell to floor		Trouble starting/stopping urine		**WOMEN ONLY:**	
Chest pain, tightness, or pressure		Sexual difficulty		Abnormal vaginal bleeding	
Distress in chest with exertion		Waking at night to urinate		Breast lump(s)	
Irregular heartbeat		**ENDOCRINE:**		Breast tenderness	
Pain or cramps in leg when walking		Chills		Vaginal itching or discharge	
Rapid heartbeat		Eating more and losing weight		Age when you had your first period?	
Rheumatic fever		Excessive thirst		Periods last how many days?	
Shortness of breath when lying flat		Fever		Date of your last menstrual cycle?	
Waking at night short of breath		Heat or cold intolerance		Menopausal? Yes No (CIRCLE ONE)	
		Increase in hair			
		Recent swelling in the neck		**MEN ONLY:**	
		Swelling in face and hands		Burning or itching from penis	
Please list any additional conditions not shown above:				Painful testicles	
				Swelling or lumps on testicles	
				Trouble getting or maintaining an erection	

Patient/Guardian Signature: _____ Date: _____