Patient Information

Patient:

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Place of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

School or N/A: _____ Grade or N/A: _____

Employer or N/A: _____ Occupation: _____

Allergies: _____

Parent's if Patient is a Minor:

Father Last Name: _____ Father First Name: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Mother Last Name: _____ Mother First Name: _____ Middle: _____

Street Address: _____

City: _____ State: _____ Zip _____

Home Phone: _____ Cell Phone: _____ Other: _____

List Three Emergency Contacts :

Last Name: _____ First Name: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Last Name: _____ First Name: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Last Name: _____ First Name: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Guarantor:

Last Name: _____ First Name: _____ Middle: _____

Street Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Email Address:

Debit/Credit Card On File

Patient/Client Last Name:	Patient/Client First Name:

Cardholder Last Name: (if not same) ⟲ Same			Cardholder First Name: (if not same)	
Card Type:	⟲ MasterCard	⟲ Visa	⟲ American Express	⟲ Discover
Telephone Number: (__ __ __) __ __ __ - __ __ __ __			Expiration Date: (mm/yyyy) __ __ / __ __ __ __	
Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ MC, VISA, Discover __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Am Ex			Verification Number: __ __ __ MC, VISA, Discover __ __ __ __ Am Ex	
Billing Address:				
City:	State:	ZIP:	Country: ⟲ United States	
Shipping Address (if not same): ⟲ Same				
City:	State:	ZIP:	Country: ⟲ United States	
Email address:				

Notes:

_____

_____

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_____

William H. Reading, MD

Recovery, Psychiatric, and Psychological Services

Child – Adolescent – Adult

Improving the Quality of Life for Individuals and Their Families

DrReading.com

Consent to Release Information

I _____ authorize Dr. William H. Reading's office to release any information due to my care to the following individuals.

_____	_____	_____
Name	Relation to patient	Phone number
_____	_____	_____
Name	Relation to patient	Phone number
_____	_____	_____
Name	Relation to patient	Phone number
_____	_____	_____
Name	Relation to patient	Phone number
_____	_____	_____
Name	Relation to patient	Phone number
_____	_____	_____
Name	Relation to patient	Phone number

_____ _____

Patient Signature Date

Practice Information and Consent to Treatment/Notice of Privacy Practices
Signature Sheet
v. 6.7.31

Dr. Reading refers to both Dr. Reading and his designees including but not limited to those professionals practicing in his offices unless including them would not make sense for the context in which the term is used.

Your signature(s) below indicate(s) you have read the practice information and consent to treatment/notice of privacy practices and agree to abide by the terms. It also indicates your clear understanding as to (1) your (your child's) responsibilities, (2) the state regulatory board(s) under whose authority William H. Reading, MD and the other professionals within his offices operate; (3) Dr. Reading's office / financial policies and your agreement to abide by these policies; (4) the nature of the services provided; (5) and your consent for Dr. Reading to consult about your care with other clinicians who practice in our offices and other clinicians who practice in our offices to consult about your care with Dr. Reading (unless specifically struck and initialed here _____).

_____

Patient Signature Printed Name Date

I, _____, Parent / Guardian / Legal Representative am legally authorized to consent and do consent and agree to the elements of the practice information and consent to treatment/notice of privacy practices on behalf of the above-named minor patient. I furthermore agree to abide by the Consent to Treatment outlined above to the extent that said contract/consent may be applied to me or involve me in any way.

_____

Parent/Guardian/Legal Representative (if applicable) Date

_____

Witness to all of the above signatures Date

William H. Reading, MD

Practice Information and Consent to Treatment/Notice of Privacy Practices
v. 6.7.31

We truly care about our patients.
Our intention is to provide the best and most scientifically advanced services in the world. We are committed to exceeding your expectations. In the real world, however, there arise certain conditions, which may interfere with this ideal. We are committed to continuous quality improvement and appreciate every suggestion, comment, complaint, and compliment. Please, direct them to Teresa our Practice Administrator and remember that some people prefer what others dislike.

Our practice is based on the best treatment options rather the minimum.
We believe in offering the best or optimal treatment options rather than the minimum, so we do not contract with any insurance companies.

You determine the maximum time of your appointment, schedule enough time to discuss what you need.
If you believe that you have difficulty communicating something, write it down and bring it to the next appointment to discuss. If you believe that you need an extended appointment please, schedule the time that you believe that you need. Patients govern the maximum time for an appointment. Write down your questions, concerns, etc. If you have a question about something on the Internet, please, print it and bring it to your appointment.

Payment is expected at the time of the appointment.
Our practice is based on a fee for service principle. We have a professional relationship with our patients and their families. We have no relationship with any insurance company and do not intend to form one. Your dealings with your insurance company are your own concern. You will be provided with a receipt that will reflect your payment for the appointment. If you choose, you may submit this to the selected insurance company with whom you have contracted. If your insurance company has additional forms, you may feel free to bring them to your appointment.

Schedule an appointment if you need time with your doctor
Except for health endangering emergencies, Dr. Reading sees patients and accepts phone calls by appointment. You may have a simple question that can be answered or taken by a staff member and relayed to Dr. Reading. If this is the case, there is no charge for this service. If you must speak with Dr. Reading directly, you will be asked to make an appointment. Each other clinician handles phone contacts in a different manner; please, ask if you have questions.

We bill for our time
While there are many ways to determine a fee for a particular service, the traditional way for psychiatrists and psychologists to bill is for the length and type of appointment. The PhD/Psychologist rate is $200 per hour for Diagnostic evaluation and individual therapy and $500 per month for group therapy. The PhD Diagnostic Evaluation is for one and one half hours. For in office appointments longer than 15 minutes Dr. Reading's rate is $300 per hour for diagnostic evaluation and individual therapy and $600 per month for group therapy. Illness and Medication Education Groups are $400 per month. Psychological testing is billed per test depending on the type of test and the amount of interpretation required.

For building entry after hours, there is a pad next to the door closest to the parking garage.
Call the office to ask for step-by-step instructions on how to use this pad if you believe that you may have difficulty using it. You may feel free to bring your mobile phone with you and we will walk you through the process.

To schedule an appointment, call 281.494.4471 or if difficulty call Teresa
To schedule appointment call the office between 10 am to closing (time varies from 5pm to 8pm to 10 pm). You may leave a message with a call back appointment to be called to schedule the appointment. If you do not receive a return call in a reasonable time, please call again.

You will still be charged if you are absent for your appointment or group
The doctor has reserved your scheduled appointment time for you and will not schedule other people during that time; thus, scheduled appointments are billed whether the patient/client is present or not unless the appointment is cancelled no less that 24hours in advance (weekends and holidays don't count as hours in this calculation). If you arrive late for your appointment it is treated the same as an absence regardless of whether or not you call. If you do not arrive on time for your appointment, you may still talk to the doctor by phone during your reserved time.

Therapy appointments have priority.
Therapy appointments are normally scheduled for same time(s) each week and take precedence over other appointments because of the need for predictability.

Psychotherapy should not end abruptly.
A course of therapy usually ends when the therapist, patient/client, or both agree that treatment goals have been met to a satisfactory level, or that progress is no longer being made. Patients/clients who are considering premature termination or with concerns or complaints about their services are urged to discuss their concerns with their therapist. Referrals to alternate sources of treatment can be provided.

We keep Protected Health Information in two sets of records.
One set is your Clinical (or Medical) Record the other is a set of psychotherapy notes. In the office, both sets of records may be kept together in the same binder but they are separate records. The Clinical Record includes reasons for seeking therapy, problems, diagnosis, goals for treatment, progress, medical and social history, treatment history, reports, and other pertinent information. By Texas law, psychological test data are not part of a Clinical record. Psychotherapy notes not a part of the Clinical Record and are for the doctor's own use.

Psychotherapy has risks as well as benefits
Therapy can result in improved relationships and resolution of concerns that led you to seek therapy. Psychotherapy requires your active involvement, effort, honesty, and openness in order for you to fully engage in the process and potentially change your thoughts, feelings, and/or behaviors. Therapy can generate difficult emotions such as anxiety, depression, or anger; sometimes symptoms get worse before better; relationships may change as personal problems and needs are explored; you may be challenged on your assumptions or perceptions or be asked to look at, think about, or handle situations in different ways. There are no guarantees of positive outcome.

For minor patients/clients …

Both parents should come to the initial appointment of a minor.

It is essential that both parents come to the initial appointment of their minor child. If this is not possible, a separate appointment should be set up for the parents to talk to the doctor.

There are limitations of the right of parents to examine a child's psychiatric/psychological records.

Parents of minor, non-emancipated patients have the right to examine the child's psychiatric records. They must also consent to any treatment. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical, or emotional abuse, the law provides that parents may not access their child's records.

Children/teens may not divulge information if privacy is not assured.

Because privacy is often crucial to successful progress, particularly with teenagers, our general is that the parents consent to suspend their access to their child's records. During treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions at separately scheduled parents' sessions. He will also provide parents with a summary of their child's treatment when it is complete, if they request. For most other issues we will work with the child to facilitate communication, unless we believe that the child is in danger or is a danger to someone else, in which case, we will notify the parents of the concern. Before giving parents any information, we will discuss the matter with the child, if possible, in order to handle any objections he/she may have.

Only bring your child for treatment if you have the right to do so.

Please, be certain that if you are bringing a minor in for evaluation or treatment, you have the legal (custodial) right to do so. If you do not have the authority to consent to treatment, you must inform us. In any case where this right might be questioned, we will ask you to provide us with written proof you your right to consent to treatment.

For those patients who are receiving medication…

If you think that you are having an adverse medication reaction, call us immediately.

It is of the highest importance that if you are having any type of adverse reaction to your medication that you notify us immediately. If you do not get a response by calling the office number, call 281.630.6210 to speak to Teresa or obtain further instructions. If you do not get an immediate response, you are urged to call 911.

If you are running out of medication, it is time for another appointment.

If you are given a prescription, you should have sufficient medication to last until then next appointment. If you are running out of medication it means that it is time for you to have another appointment so that the doctor may check your condition and refill the medication. It is your responsibility to make an appointment <u>before</u> you are out of medication.

There are minimum standards of appointment frequency.

The psychiatric standard of care requires that patient's are evaluated at a minimum of every 3 months to determine the effectiveness of the medication, side effects, complications of other illnesses, and need for continued use of the medication. We do not make the prescription laws but we are responsible for monitoring the condition of patients and determining the appropriateness of each prescription we write.

The charge for a medication refill without an appointment is $25
To cover the time and effort that it takes pull a chart, read the last note, write a prescription, stamp, address and mail an envelope we charge twenty-five dollars. If the prescription must be called in, there is time spent in calling the pharmacy, navigating the system, and dictating the prescription to the pharmacist.

Consent to Treatment/Notice of Privacy Practices

I, the undersigned patient, have chosen to receive psychiatric/psychological services from William H. Reading, MD and/or his designee(s), hereinafter referred to as Dr. Reading*. My choice has been voluntary and I understand that I may terminate treatment at any time. If I terminate treatment, I will inform Dr. Reading in writing. I understand that Dr. Reading may terminate treatment with me at any time upon thirty days written notice to the last address in his records whether or not I have acknowledged receipt of this notice.

*Dr. Reading refers to both Dr. Reading and his designees including but not limited to those professionals practicing in his offices unless including them would not make sense for the context in which the term is used.

I understand that Dr. Reading is limiting his practice to psychiatry (or the licensed area of practice in the case of a designee), and I will see my primary physician for checkups and any and all medical problems. I understand that Dr. Reading will refer me to another physician or professional should he believe that it is necessary, and I will to go to referral appointments. I will hold Dr. Reading harmless for any and all adverse outcomes if I do not follow any referral recommendation or see my primary physician. I consent to the release of information to my primary physician and consultants, and I understand that Dr. Reading will share information, including but not limited to medications, evaluations, progress, and diagnoses. I also consent to the release of information from my primary physician to Dr. Reading. I will sign releases of information allowing these activities. I will hold Dr. Reading harmless for the actions of any other physician or healthcare professional, including but not limited to those practicing within his offices and I will hold any other physician or healthcare professional including but not limited to those practicing within his offices, harmless for the actions of Dr. Reading.

I understand that all communications and records of information collected about me will be protected or released in accordance with state and federal laws regarding confidentiality of such records and information. I understand that state laws require Dr. Reading to report all cases of abuse or neglect of minors or the elderly. I understand that there may be other circumstances in which the law requires disclosure of confidential information. I understand that Dr. Reading will release medically necessary information for my treatment in an emergency situation. I will hold Dr. Reading harmless for any further release or distribution of Protected Health Information (PHI) by a third party and any breach of privacy associated with the electronic transmission of PHI that is otherwise authorized or legally allowed.

I understand that I will have the opportunity to participate in the development of a plan for my treatment and that any recommendations will be explained to me. I understand that I have the obligation to ask questions regarding any treatment recommendation(s) if I do not fully understand. I agree to hold Dr. Reading harmless for any failure on my part to ask questions when I do not understand. I understand that I have the right to accept or reject any treatment recommendation at any time, including but not limited to any medication recommendation. If I choose to follow or not to follow any of Dr. Reading's recommendations, I agree to hold Dr. Reading harmless for any injury to me arising from my own decisions. If I am taking any

medications and am having any side effect or adverse reaction whether explained to me or not and I choose to continue taking this medication without discussing this side effect or adverse reaction with Dr. Reading, I agree to hold Dr. Reading harmless for my decision. I agree to hold Dr. Reading harmless for any side effects or adverse reactions to any treatments prescribed or administered under Dr. Reading's supervision when I have consented through this or any other consent for treatment. I agree to read any and all literature available to me or furnished by Dr. Reading or his staff for the purpose of informed consent. I understand that a copy of the Physician's Desk Reference is available and that Dr. Reading or his staff will answer any and all questions for the purpose of informed consent. I understand that medication education is available at the pharmacy where I fill any medication prescribed by Dr. Reading and agree to use this service if I have any questions regarding a medication. I understand that information is available regarding medication on the Internet. I understand that information on the Internet is not necessarily true and will ask Dr. Reading about information before I act on it. If I do not ask Dr. Reading about information I have read on the internet and I act on it, I will hold Dr. Reading harmless for any consequences of this action.

I understand that I have the responsibility for procurement, proper care, storage, and security of the medications prescribed to me by Dr. Reading and that if refills are not available on the current prescription it is my responsibility to make an appointment so that another prescription is given. I understand that it is my responsibility to assure that the medication is not lost, stolen, or destroyed. I understand that medication prescribed by Dr. Reading may not be dispensed without a prescription and that it is illegal to exchange prescription medication with another person without a prescription. I will hold Dr. Reading harmless for consequences of my acts and/or omissions regarding medications prescribed by Dr. Reading and from my failure to procure properly, care for, secure, store, or otherwise conserve said medication.

I understand that my participation in the recommended treatment, including but not limited to attending all scheduled appointments, is necessary to achieve the best possible outcome. I understand that I will be billed for any missed appointments or any appointments cancelled within 24 hours of the appointment (weekends or holidays are not included in the count of the 24 hours). If I miss an appointment, I understand that there is no assurance that I will be worked-in the same day or otherwise seen before prescribed medication is depleted. I understand that showing late for an appointment is the same as missing the appointment regardless of whether or not I notify the office of my lateness. If I miss my appointment, I understand that I am still responsible for payment of the full appointment time whether or not Dr. Reading is able to spend less time with me on a work in basis. If Dr. Reading is trying to work me in after I have missed an appointment, I understand that any patient coming to an appointment on time may be seen ahead of me and that I may be asked to reschedule if I am late.

I understand that there is no assurance or guarantee that I will feel better. In fact, there are no guarantees that any medical or psychiatric illnesses will respond to treatment by any physician. I am contracting with Dr. Reading for his services and specifically not contracting for Dr. Reading to guarantee improvement.

I understand that Dr. Reading's practice is currently limited to outpatient treatment and that I am responsible for securing an inpatient facility and inpatient physician for treatment should this become necessary. I understand, if emergency diagnosis or treatment is necessary for any emergency medical or psychiatric problem (whether or not diagnosed or treated by Dr. Reading), that I am responsible for seeking emergency treatment at a local emergency room or psychiatric facility.

I understand that working through problems is part of the development of good mental health. If I have any misunderstandings with Dr. Reading, I agree to work with him to resolve any differences in opinion. If there is no satisfactory resolution after this, I agree that I will submit the matter to an independent arbitrator. I agree not to enter into any contingency agreement with any attorney at law for the purpose of litigation regarding any and/or all aspects of this consent for medical services. I understand that if litigation is necessary to secure payment of unpaid bills that my name as well as the name of any responsible party will be used. I waive my right of confidentiality only to the extent of legal necessity for a burden of proof in such litigation in small claims court. I agree that, if any litigation is necessary regarding any aspect of my treatment by Dr. Reading, the total legal expenses and any and all costs caused by and/or incurred from said litigation for all parties is to be paid by the party who does not prevail.

I understand that Dr. Reading is licensed to practice medicine by the Texas State Board of Medical Examiners and Board Certified by the American Board of Psychiatry and Neurology (Psychiatry). Other designees if licensed are responsible to the particular organization regarding their profession(s). I also understand that Dr. Reading is not Board Certified in any other medical specialty including but not limited to the American Board of Child and Adolescent Psychiatry. I understand that Dr. Reading will practice according to the laws of the State of Texas and the ethical principles of the American Medical Association.

I understand that the Practice Information and Consent to Treatment/Notice of Privacy Practices are the only binding documents between Dr. Reading and me and that no other contract, implied or otherwise, will apply to the physician-patient/professional-client relationship between Dr. Reading and me.