



URSHEL  
RECOVERY SCIENCE  
INSTITUTE

**Dr. Harold C. Urschel, III, MD, MMA**  
**Dr. Kevin Gilliland, PsyD**  
**Dr. Irina Gromov, MD, PhD**  
**Dr. Jeanie Zelanko, RN, CNS, PhD**  
**Dr. Larry Hanselka, PhD**

**Welcome!** We understand that addiction is a chronic medical illness — no different from other chronic illnesses such as diabetes or asthma. Our medical practice specializes in addiction psychiatry and therapy. Therefore, we can offer support and help to you in understanding and fighting this disease through treatment, without disruption to your everyday life. We offer several different personalized treatment plans based upon your needs and requirements.

An appointment has been scheduled for you at our office on:

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Provider: \_\_\_\_\_

At the outset of our relationship, we will need to perform a thorough psychiatric history and evaluation with you in order to best assess our ability to help you in your current situation. Consequently, we ask that you complete our patient registration packet **prior to your appointment**. This will allow us to spend less time “taking your history” and more time strategizing with you about how best to treat your current needs(s). If you are not able to complete all components of this packet prior to your arrival, we may not be able to complete your assessment in the first visit. Consequently, we will require a second visit in order to complete the evaluation and treatment plan best suited to your needs.

We take our responsibility to help you seriously. Your first visit with us will be a consultation. At that time, we will determine if a mutual, on-going relationship would be acceptable.

We sincerely look forward to the privilege of helping you.

Best regards,

Jean Wilson  
Practice Administrator

## **GENERAL PRACTICE INFORMATION AND POLICIES**

**Our Location:** 8222 Douglas Avenue, Suite 375, Dallas, Texas (One Preston Center Building). Parking is available on each side of the building or in the parking garage located behind the building. Reserved parking is available for you on the 3<sup>rd</sup> floor, numbers 113, 114, 115, 116, 118 and 119.

**New Patient:** Your first appointment will consist of a full psychiatric assessment; the consultation fee is \$395.

**Medical Information:** Please complete the attached patient assessment completely. If you have medical records or laboratory results, please bring them with you. Laboratory results older than six months are not viable. We will order laboratory testing to ensure we have the most up to date information available.

**Current Medication(s):** Please bring the medications you are currently taking with you.

**Medical Insurance:** Please bring your current insurance card(s) and picture ID. This will help us file for insurance reimbursement on your behalf. Insurance reimbursement may not cover all services. Regardless of insurance, payment remains your responsibility.

**Appointment Cancellations:** Our office sees patients by appointment only. If you are unable to keep your appointment, please notify us at 214.890.6724 or 214.890.6742 as soon as possible, so we are able to offer your appointment time to another patient.

**Late Appointment:** Please be on time for your appointment. **If you arrive more than ten (10) minutes late to an appointment we will not be able to see you.** The appointment will have to be rescheduled and you will be charged a late cancellation fee of \$150.

**Office Management:** You can reach Jean Wilson, our Practice Manager, at 214.890.6728.

### **Appointments:**

- Our office opens at 8:00 am, Monday through Friday, except for holidays, which will be posted in advance.
- Our office closes from 12:00 noon to 1:00 PM for lunch.
- Our office closes at 5:00 pm unless other appointment arrangements have been made between our providers and patients.
- Patient appointments are scheduled by calling the office during regular office hours.

**Appointment Reminders:** The day prior to your appointment, we will notify you via telephone (unless you indicate you prefer e-mail contact) of the date, time and co-pay amount of your next visit. However, if we cannot reach you, it is your responsibility to keep your appointment.

**Patient Information:** It is **your responsibility** to advise our office of any change(s) to your insurance coverage, address, telephone number(s), or other pertinent patient information.

**Notice of Privacy Practices:** Upon registration at The Urschel Recovery Science Institute, you will be asked to sign and you will receive a copy of our Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We take the privacy of your information very seriously. This notice of Privacy Practices is effective beginning April 14, 2003. If you have any questions please contact our office at 214.905.5090.

### **Prescriptions and Prescription Refills:**

- Prescriptions provided by our providers will be given to you on the date of service. Any requests for prescription refills must be faxed to our office (214.905.1998) by your drugstore. Prescription refills will be handled within one business day of receipt.
- **Requests for prescription refills will not be authorized during the weekend** – only Monday through Friday during normal business hours.

### **Emergency (Critical) Situations:**

- If a situation poses immediate risk to health and life, call 911 and/or go to the nearest Emergency Room immediately.
- After normal business hours, you may call our general number at 214.905.5090 or our answering service at 972.943.4426.
- You may call the Practice Administrator, Denean (Dennie) Evans, at all times at 214.728.4463.

### **Financial Policy:**

- Payment is due at time of service by cash, check, Visa, MasterCard or Discover.
- Patients are responsible for their co-payments and/or deductibles, which must be collected at the time services are rendered, due to insurance regulations.
- A copy of your credit card will be made and kept in your file.
- NSF checks returned by your bank will be collected in cash only, and a fee of \$35 will be charged to you.

**Patient Cancellations and Failure to Arrive for a Scheduled Appointment:** A late cancellation fee of \$150 will be charged for any appointment **not cancelled or rescheduled 24 hours in advance**. A fee of \$190 will be charged for an appointment that has been made and **not kept (no-show)**. Please call 214.890.6724 or 214.890.6742 to avoid being charged for a late cancellation or a no-show appointment.

**Additional Services:** There are various services rendered by your provider that are not covered by your insurance. In many instances, even though we attempt to obtain accurate information from your insurance company regarding your treatment coverage, we find that your insurance does not pay. We will file your insurance as a courtesy to you. In the event your insurance does not pay, or only pays partial costs, any balance that is not contractually agreed for adjustment will be your personal responsibility. Additional services can include:

- *Medical records* provided to the patient or entities other than medical providers, when approved by the patient. In this case, there is a fee of \$35 for the first five pages and \$1.00 per page thereafter, per record provision. Additional fees may be assessed for extensive records.
- A fee of \$25 will be charged to the patient for preparation of *special letters or short documents* provided to entities other than medical providers.
- *Consultations provided by the physician or nurse practitioner to third parties* as requested or agreed to by the patient. A fee of \$250 will be charged based on the time involved in the consultation.
- *Medical report provision or completion of forms for entities other than medical providers.* All medical reports and/or forms are completed at a cost of \$35. Additional fees may apply, depending on the complexity of the documentation. Any additional costs will be discussed with the patient prior to completion of these records.
- *Payment for legal services* provided on behalf of the clinician due to actions of the patient or the patient's family, which requires legal intervention to protect the patient's records will be charged to the patient at a rate of \$250 per hour.

**PATIENT REGISTRATION INFORMATION**

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ DRIVER'S LIC. # \_\_\_\_\_

SINGLE: \_\_\_ MARRIED: \_\_\_ DIVORCED: \_\_\_ WIDOWED: \_\_\_ OCCUPATION: \_\_\_\_\_

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NAME OF SPOUSE OR NEXT OF KIN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
(If different from patient)

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMPLOYED: YES or NO EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

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REFERRAL SOURCE: \_\_\_\_\_ MEDICAL INSURANCE COVERAGE: Y \_\_\_\_\_ N \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT: \_\_\_\_\_ INSURANCE COMPANY NAME: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ INSURED'S SS#: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_ INSURED'S NAME: \_\_\_\_\_

INSURED'S SOCIAL SS# \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

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PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**CONSENT TO RELEASE CLAIMS AND ASSIGNMENT OF BENEFITS**

I authorize the release of any protected information necessary to process insurance claims. I also authorize payment of medical benefits to The Urschel Recovery Science Institute for services rendered.

I hereby assign and transfer to The Urschel Recovery Science Institute all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the insurance company I named on my patient registration form. I hereby consent for The Urschel Recovery Science Institute or its agents to release and disclose my protected health information (or the patient's I am responsible for) to my insurance carrier, claims administrator, managed care company, review agency or their agents for the purpose of treatment , healthcare operations, and evaluation claims for payment.

I understand insurance billing is a service provided as a courtesy and that at all times I am personally responsible for any fees not covered by my insurance carrier. Should any insurance payments be made directly to me or to the insured for monies due on my account, I agree to immediately reimburse these funds to The Urschel Recovery Science Institute. I also acknowledge that I am responsible for any deductible, co-payment, or other balance not covered by my insurance carrier.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**GUARANTOR'S FINANCIAL INFORMATION AND AGREEMENT**

I agree to all of the policies as stipulated above in the Urschel Recovery Science Institute patient packet. By signing my name to this document, I agree that I understand I am responsible for all patient charges. I agree that if I choose to pay on my account with cash, check, money order, Visa or MasterCard, I will review my account and discuss any issue(s) I have **prior to payment**. I will not stop payment on any check I produce for payment of services.

I agree to keep my credit card on file for purposes of payment for services rendered, late cancellations and appointments not kept. I also agree that I will accept these charges and if I choose to pay with my credit card I will not dispute the charge with my credit card company.

MY CREDIT CARD INFORMATION IS AS FOLLOWS.

PLEASE PRINT YOUR NAME: \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CREDIT CARD NUMBER

\_\_\_\_\_  
SECURITY CODE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
EXP. DATE

**I HAVE READ AND UNDERSTAND MY FINANCIAL RESPONSIBILITY AND I ACCEPT AND AGREE TO THE TERMS OF THIS AGREEMENT IN ITS ENTIRETY.**

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**CONSENT/AUTHORIZATION FOR EXCHANGE OF MEDICAL RECORDS, INSURANCE OR PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_

The patient named above authorizes The Urschel Recovery Science Institute (Harold C. Urschel III, M.D., MMA; Irina Gromov, MD, PhD; Kevin Gilliland, PsyD; Jeanie Zelanko, RN, CNS, PhD; Larry Hanselka, PhD,) to exchange medical records, insurance information or patient information. No limitation is placed on the dates, history of illness or diagnostic and therapeutic information, including treatment for alcohol/drug abuse or psychiatric treatment, unless specifically specified below.

Person or company to exchange information: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or legally authorized representative

\_\_\_\_\_  
Date

## GENERAL CONSENT TO RELEASE INFORMATION

By your signature, you are consenting to give the individual(s) listed below information regarding your medical condition and/or financial information. You may leave any of the following information blank if you object to giving out your information. No limitation is placed on the dates, history of illness or diagnostic and therapeutic information, including treatment for alcohol/drug abuse or psychiatric treatment, unless specifically specified below. You may change this information at any time. To do so, please contact our office.

1. If we may inform family members or other persons about your medical condition and diagnosis, please print their names and telephone numbers:

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2. For emergency purposes only, please print the phone number and names of the family members or persons whom we may inform about your medical condition:

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3. Please print a phone number, if other than your home phone, where you want to receive calls regarding information for appointments, diagnoses, or other health information:

(\_\_\_\_) \_\_\_\_\_

4. Please print the appropriate address if you want to use an address other than your home address to receive billing statements and/or other correspondence:

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5. Can we leave confidential messages such as appointment reminders on your home phone, answering machine or voicemail? Or, if you gave us another phone number to call, can we do the same on that phone number?

YES \_\_\_\_\_ NO \_\_\_\_\_

6. If you do not have an answering machine or voicemail, can a confidential message be left at your place of employment?

YES \_\_\_\_\_ NO \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

## CONSENT TO EXCHANGE INFORMATION WITH PRIMARY CARE PHYSICIAN (PCP)

Communication between behavioral health providers and your PCP is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication. You may revoke this consent at any time, except to the extent that action has been taken in reliance upon. Unless otherwise specified, this consent shall expire six months from the date of signature.

I, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, for the purpose of coordinating care,  
(Patient Name) (Patient DOB) (Patient SSN)

authorize The Urschel Recovery Science Institute to exchange information indicated in the "Consent" portion of this form to:

PCP Name \_\_\_\_\_ Fax \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I have read and understand the above information and give my consent (please check one):

- To release any applicable mental health/substance abuse information to my PCP
- To release only medication information to my PCP
- I do not give my consent to release any information to my PCP

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Witness Signature Date

### INFORMATION FOR PCP:

The patient was seen by me on (date): \_\_\_\_\_ for (Diagnosis) \_\_\_\_\_  
Treatment Plan:

\_\_\_\_\_

### FOR PSYCHIATRIST ONLY:

The following medication(s) was/will be started (List medications and dosages):

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Medication was not indicated \_\_\_ Patient refused medication \_\_\_ Psychotherapy suggested before trying Meds.

\_\_\_\_\_  
Provider Signature Date

**CONSENT TO URINE DRUG TEST/BREATHALYZER**

I, \_\_\_\_\_, give my consent for The Urschel Recovery Science Institute to randomly test me for drugs and/or alcohol at my initial consultation and during the course of my treatment. This consent is in effect as long as I am a patient at The Urschel Recovery Science Institute.

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Patient Signature

Date

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Witness

Date

# COMPREHENSIVE PATIENT ASSESSMENT QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Presenting Information

What are the main problems that brought you to our practice?

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When did these problems first begin?

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Please check the statement below that best describes the course of these problems since they began:

- The problems have stayed about the same since they started.
- The problems have steadily worsened since they started.
- The problems seem to come and go. By the time I feel almost back to my usual self, the problems usually come back.
- The problems have ups and downs but haven't gone away completely since they started.

Have you had a past period in which you had similar problems? If so, when?

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**For office use only:**

**Below are listed several areas of functioning. Please check any which have been worsened due to your current problems.**

- |   |  |
|---|--|
| <input type="checkbox"/> My job performance   | <input type="checkbox"/> My relationship with my spouse or significant other       |
| <input type="checkbox"/> My relationship with my family   | <input type="checkbox"/> My ability to manage my usual chores at home              |
| <input type="checkbox"/> My interest in keeping up my appearance  | <input type="checkbox"/> My ability to be the kind of parent that I want to be     |
| <input type="checkbox"/> My ability to control my temper  | <input type="checkbox"/> My ability to control my behavior (acting before I think) |
| <input type="checkbox"/> My ability to carry out my usual leisure interests and hobbies                             |  |
| <input type="checkbox"/> My ability to plan for my future and set goals for myself                                  |  |
| <input type="checkbox"/> My ability to carry out my usual social life with friends, activities, organizations, etc. |  |
| <input type="checkbox"/> Any other way your functioning has been effected? If so, please explain _____              |  |

## Psychiatric History

Have you ever attempted Suicide? \_\_\_Yes \_\_\_ No If yes, please state when and what type of treatment(s) you experienced:

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Have you had psychological testing in the past? \_\_\_Yes \_\_\_ No When \_\_\_Where \_\_\_ Can you provide a copy? \_\_\_\_\_

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**Past Mental Health History - Please list any previous psychiatrists psychologists or therapists you have seen:**

Name of Person Seen	Dates Seen (mo/yr-mo/yr)	Medications Prescribed	Reasons Seen	Hospitalized? (Yes/No-Where)
1.				
2.				
3.				
4.				

## Family History

List any blood-relatives (parents, siblings, grandparents, aunts, uncles, cousins, etc.) who have any history of any emotional problems (depression, manic-depression, anxiety, schizophrenia, drug/alcohol abuse, suicide)

Relation (Father, Aunt, Daughter, etc.)	Father/Mother's Side of Family	Problem (Depression, Alcoholism, etc.)	Ever Hospitalized? (yes/no)	Medications They Took (If known)
1.				
2.				
3.				
4.				

**For office use only:**

## Substance Use

Have you ever had treatment for substance use? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, where and when? \_\_\_\_\_

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### Alcohol

When was the last time you drank anything containing alcohol?

How many days per month do you drink? \_\_\_\_\_

How many drinks do you have in an average week? \_\_\_\_\_

What is your typical pattern of alcohol use?

\_\_\_\_\_ Everyday      \_\_\_\_\_ Most Days      \_\_\_\_\_ Weekends      \_\_\_\_\_ Payday Binges

Where, and with whom, do you usually drink?

What type of alcohol do you usually have (i.e., beer, wine, liquor)? \_\_\_\_\_

Have you ever felt you were drinking too much? \_\_\_\_\_

Have you ever tried unsuccessfully to stop drinking? \_\_\_\_\_

What is the longest period (specify days, months or years) that you have ever had without drinking alcohol? \_\_\_\_\_

Have you ever had any of the following physical withdrawal symptoms when abstaining from alcohol?

\_\_\_\_\_ Shakes or Tremors      \_\_\_\_\_ Hallucinations      \_\_\_\_\_ Insomnia      \_\_\_\_\_ Restlessness  
\_\_\_\_\_ Seizures      \_\_\_\_\_ Night Sweats      \_\_\_\_\_ Vomiting Blood      \_\_\_\_\_ Other (specify): \_\_\_\_\_

Have you ever had any of the following problems related to your alcohol use?

\_\_\_\_\_ Liver problems      \_\_\_\_\_ Pancreatitis      \_\_\_\_\_ Other (specify) \_\_\_\_\_ First Time? \_\_\_\_\_

### Drugs

Have you ever used any of the following?

Substance	Yes or No?	If yes, when was the last time?	Have you ever felt you had a problem with these drugs? (Yes or No)
Marijuana			
Cocaine			
Crack			
Amphetamine			
LSD			
PCP			
Heroin			
Prescription Drugs?			
Other (Please specify)			

What is your typical pattern of drug use? \_\_\_\_\_ Everyday \_\_\_\_\_ Most days \_\_\_\_\_ Weekends \_\_\_\_\_ Payday binges

## Substance Use (continued)

Where, and with whom, do you usually use drugs?

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How much do you typically spend on drugs each month? \$ \_\_\_\_\_

Have you ever used IV drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever had any blackouts? \_\_\_\_\_ If yes, when was the last time? \_\_\_\_\_

Have you ever abused any prescription medications? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, which one(s)? \_\_\_\_\_

What is the longest period (specify days, months or years) that you have ever had without using drugs?

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Have you ever had any of the following physical withdrawal symptoms when you abruptly stopped using drugs?

\_\_\_\_\_ Fever                      \_\_\_\_\_ Craving                      \_\_\_\_\_ Excess Sweating                      \_\_\_\_\_ Cramping

\_\_\_\_\_ Insomnia                      \_\_\_\_\_ Restlessness                      \_\_\_\_\_ Other (specify) \_\_\_\_\_

Have you ever had any of the following medical problems related to your drug use?

\_\_\_\_\_ Chest Pain or Discomfort                      \_\_\_\_\_ Problems with Breathing                      \_\_\_\_\_ Weight Loss                      \_\_\_\_\_ Seizures

**Please check any of the following relating to your alcohol or drug use:**

\_\_\_\_\_ Yes \_\_\_\_\_ No

I've felt alcohol or drugs were causing a problem for me

\_\_\_\_\_ Yes \_\_\_\_\_ No

I've felt guilty about my use

\_\_\_\_\_ Yes \_\_\_\_\_ No

Others have annoyed me by talking about or criticizing my use

\_\_\_\_\_ Yes \_\_\_\_\_ No

I've had a desire (or made unsuccessful efforts) to cut down or control my use

\_\_\_\_\_ Yes \_\_\_\_\_ No

I've tried unsuccessfully to control my use

\_\_\_\_\_ Yes \_\_\_\_\_ No

I've used alcohol or drugs more often or in larger amounts than I intended

\_\_\_\_\_ Yes \_\_\_\_\_ No

I've had to increase my use of alcohol or drugs to get the desired effect

\_\_\_\_\_ Yes \_\_\_\_\_ No

I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I've cut down or stopped using alcohol and/or drugs

\_\_\_\_\_ Yes \_\_\_\_\_ No

I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous

\_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever attended meetings on a regular basis of at least 1/week for 3 months?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Are you still attending meetings regularly?

How many meetings per week do you usually attend? \_\_\_\_\_

What was the date of your last meeting? \_\_\_\_\_

Why did you stop attending regularly? \_\_\_\_\_

Do you smoke cigarettes or use any tobacco products? \_\_\_\_\_ YES \_\_\_\_\_ NO If yes, what and how often?

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Are you intending to quit soon? \_\_\_\_\_ YES \_\_\_\_\_ NO

## Medical History

Who is your family doctor or "main" doctor? \_\_\_\_\_ When was your last appointment? \_\_\_\_\_

When was the last time you had lab work? \_\_\_\_\_

Has your family doctor or other doctor prescribed antidepressants or sedatives for you currently or in the past?

If so, what medication(s)? \_\_\_\_\_

## Medical History (continued)

### Current Medications – Please list any medications you are currently taking:

Medication	Dose (mg)	Times per day	When you started this medication (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

\* Please list any medication allergies: \_\_\_\_\_

### Past Psychiatric Medications - Please list any medications that you previously took on a regular basis but are not taking now.

Medication	Dose (mg)	Times per day	When you started this medication (mo/yr)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

## Educational History

How well did you like school? \_\_\_\_\_ What kind of grades did you make in school? \_\_\_\_\_

Describe your social life at school (circle one): active, normal, loner, other (explain: \_\_\_\_\_)

What things got you in trouble at school? \_\_\_\_\_

Did you attend college? \_\_\_\_\_ Where? \_\_\_\_\_

What was your major? \_\_\_\_\_

What is your highest educational level or degree attained? \_\_\_\_\_

**For office use only:**

## Social History

### Family Background and Childhood History

What is your current age? \_\_\_\_\_ Were you adopted? \_\_\_\_\_ Where were you raised? \_\_\_\_\_

Please list any siblings and their age(s): \_\_\_\_\_

What was your father's occupation? \_\_\_\_\_ What was your mother's occupation? \_\_\_\_\_

## Parental Background

Did your parents divorce? \_\_\_\_\_ If so, how old were you when they divorced? \_\_\_\_\_ If your parents divorced, who raised you?  
\_\_\_\_\_ How old were you when your father remarried? \_\_\_\_\_ When your mother remarried? \_\_\_\_\_  
Describe your father and your relationship with him: \_\_\_\_\_

Describe your mother and your relationship with her: \_\_\_\_\_

What things did you get into trouble for at home? \_\_\_\_\_

How was discipline handled at home? \_\_\_\_\_

How old are your parents currently? Dad \_\_\_\_\_ Mom \_\_\_\_\_ How old were you when you left home? \_\_\_\_\_

Were you ever physically or sexually abused? \_\_\_\_\_ If so, at what age(s)? \_\_\_\_\_

Has anyone in your immediate family died? \_\_\_\_\_ Who and when? \_\_\_\_\_ Reason \_\_\_\_\_

## Occupational History

Are you currently working? \_\_\_Yes \_\_\_No

How long have you been in your present position? \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Where do you work? \_\_\_\_\_

Where have you worked before and how long (summary only)? \_\_\_\_\_

Have you ever been in the military? \_\_\_Yes \_\_\_No (If no, then skip this section and move on to symptom checklist)

Branch \_\_\_\_\_ Date entered \_\_\_\_\_ Date discharged \_\_\_\_\_

Type of discharge \_\_\_\_\_ Rank at discharge \_\_\_\_\_

Location of service \_\_\_\_\_

Did you have any psychological problems related to combat experience? \_\_\_Yes \_\_\_No

Do you have a service-connected disability? If so, specify: \_\_\_\_\_

## Legal Information

Have you ever been stopped by the police for driving under the influence of alcohol or drugs? \_\_\_Yes \_\_\_No

If yes, how many times have you been stopped? \_\_\_\_\_

Have you ever been charged with or convicted of a DUI/DWI, public intoxication or other substance related crime? \_\_\_Yes \_\_\_No

If yes, list each time: \_\_\_\_\_

Have you ever received convictions for any crime? \_\_\_Yes \_\_\_No

If yes, for what crimes? \_\_\_\_\_

Have you ever spent time in jail and/or prison? \_\_\_Yes \_\_\_No

If yes, for how long? \_\_\_\_\_

Are you currently on probation or parole? \_\_\_Yes \_\_\_No

If yes, for what convictions? \_\_\_\_\_ Condition(s) of Probation \_\_\_\_\_

## Marital and Family History

Are you currently \_\_\_Married \_\_\_Divorced \_\_\_Single \_\_\_Widowed How long? \_\_\_\_\_

If married, what is your spouse's occupation? \_\_\_\_\_ Where employed? \_\_\_\_\_

Describe your relationship with your spouse or significant other: \_\_\_\_\_

Have you had any prior marriages? \_\_\_\_\_ If so, how many? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you have any children? \_\_\_\_\_ Ages? \_\_\_\_\_

List everyone who currently lives at home: \_\_\_\_\_

Do you attend church? \_\_\_\_\_ Where? \_\_\_\_\_ How often? \_\_\_\_\_

## Symptom Checklist

Please check any of the following that may have been particularly stressful to you in the last several weeks:

- |   |   |
|---|---|
| <input type="checkbox"/> Job related stress<br><input type="checkbox"/> Death or loss of loved one<br><input type="checkbox"/> Conflict with children<br><input type="checkbox"/> Conflict with parents or extended family<br><input type="checkbox"/> Financial pressure | <input type="checkbox"/> Marital conflict<br><input type="checkbox"/> Move/Loss of contact with friends or family<br><input type="checkbox"/> Children with behavior problems<br><input type="checkbox"/> Family member with an alcohol or drug problem |
|---|---|

Please check any of the following symptoms which occur for most of the day, nearly every day, for periods longer than several days at a time:

Recent	Past		If recent, when was the last episode?	How frequently do you experience episodes?
<input type="checkbox"/>	<input type="checkbox"/>	Depressed or sad mood	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Loss of interest or pleasure in things I'm normally interested in	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty falling asleep	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty staying asleep or waking up too early	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping too much	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite/Weight gain (____ lbs.)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decreased appetite/Weight loss (____ lbs.)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue/Poor energy level	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decreased activity (work, social, physical, sexual)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration or slowed thinking	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive feelings of guilt or worthlessness	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Decreased sex drive or interest	_____	_____

Please check any of the following symptoms which have occurred for more days than not for months at a time:

Recent	Past		If recent, when was the last episode?	How frequently do you experience episodes?
<input type="checkbox"/>	<input type="checkbox"/>	Excessive anxiety or worry for no good reason	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Trembling, twitching or feeling "shaky"	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Muscle tension or muscle aches	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Easily fatigued	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or lightheadedness	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nausea, diarrhea or other stomach problems	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Feeling keyed up or on the edge	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Trouble falling or staying asleep	_____	_____

Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

Recent	Past		If recent, when was the last episode?	How frequently do you experience episodes?
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks/anxiety attacks	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Persistent worry that I will have a panic attack	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart pounding or racing heart	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Trembling or shaking	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sweating	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Choking	_____	_____

### Symptom Checklist (continued)

<input type="checkbox"/>	<input type="checkbox"/>	Nausea or stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of unreality	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling sensations	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feeling of smothering or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Fear of dying	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Fear of going crazy or doing something uncontrolled	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chest pains or discomfort	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, unsteady feelings or faintness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Avoiding situations or places that may cause panic	<input type="checkbox"/>	<input type="checkbox"/>

Please check any of the following symptoms which have occurred for most of the day, for more than four days at a time: **(Bipolar)**

<b>Recent</b>	<b>Past</b>		<b>If recent, when was the last episode?</b>	<b>How frequently do you experience episodes?</b>
<input type="checkbox"/>	<input type="checkbox"/>	Euphoric or "high" mood	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Irritable mood (getting angry easily)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Decreased need for sleep without feeling tired	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Increased energy level	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Increased activity (work, social, physical, sexual)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts speeded up or racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Much increased talkativeness or being much more socially outgoing	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Making decisions too impulsively	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Going on spending sprees	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever experienced any of the following symptoms?

<b>Recent</b>	<b>Past</b>		<b>If recent, when was the last episode?</b>	<b>How frequently do you experience episodes?</b>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices that sound real even though they are not actually there	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Vivid voices in my head that do not seem like my ideas	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feeling that others might be putting thoughts in my head	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feeling others might be able to read my thoughts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Others feeling I am too suspicious or paranoid	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Feeling others might be talking about me	<input type="checkbox"/>	<input type="checkbox"/>

Please check any of the following disturbances in eating habits or maintaining your normal weight that you have experienced:

<b>Recent</b>	<b>Past</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Insistence on maintaining body weight below expected for age and height
<input type="checkbox"/>	<input type="checkbox"/>	Intense fear of gaining weight or becoming fat even though underweight
<input type="checkbox"/>	<input type="checkbox"/>	I feel "fat" even when others see me as underweight
<input type="checkbox"/>	<input type="checkbox"/>	Eating binges
<input type="checkbox"/>	<input type="checkbox"/>	Feeling of lack of control of eating during eating binges
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting or using laxatives to prevent weight gain
<input type="checkbox"/>	<input type="checkbox"/>	Being overly concerned about body weight and shape

## Symptom Checklist (continued)

Please check any of the following disturbances that apply to you:

**Recent    Past**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I tend to do things on impulse which end up being damaging to me or others                |
| <input type="checkbox"/> | <input type="checkbox"/> | I have mood swings (depression, irritability, anxiety, anger) lasting up to several hours |
| <input type="checkbox"/> | <input type="checkbox"/> | I have tried to commit suicide  |
| <input type="checkbox"/> | <input type="checkbox"/> | I have made cuts, burns, or other injuries to myself without wanting to kill myself       |
| <input type="checkbox"/> | <input type="checkbox"/> | My relationships always seem to work out wrong  |
| <input type="checkbox"/> | <input type="checkbox"/> | My mood often shifts from being overconfident to having very low self esteem              |
| <input type="checkbox"/> | <input type="checkbox"/> | I have a hard time sympathizing with others' physical or emotional pain                   |
| <input type="checkbox"/> | <input type="checkbox"/> | I often feel others do not understand me  |
| <input type="checkbox"/> | <input type="checkbox"/> | I tend to get very hurt or angry when I am criticized or rejected by someone              |
| <input type="checkbox"/> | <input type="checkbox"/> | I tend to need a lot of reassurance or approval from others                               |
| <input type="checkbox"/> | <input type="checkbox"/> | I am very concerned about my appearance   |
| <input type="checkbox"/> | <input type="checkbox"/> | Others often expect too much of me  |

Please check any of the following problems relating to past severe trauma or stress that apply to you:

**Recent    Past**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it |
| <input type="checkbox"/> | <input type="checkbox"/> | I have a history of relatives hurting me physically or touching me in sexual areas                         |
| <input type="checkbox"/> | <input type="checkbox"/> | I have memories of a stressful event that I have trouble putting out of my head                            |
| <input type="checkbox"/> | <input type="checkbox"/> | I sometimes have flashbacks of past events, or I act or feel as though I am re-living a stressful event    |

Please check any of the following obsessions or compulsions that apply to you:

**Recent    Past**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive doubting or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my head |
| <input type="checkbox"/> | <input type="checkbox"/> | Urges to check things, wash things, or count repeatedly  |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive concern about coming in contact with germs or dirt   |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive concern with right/wrong or morality   |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive need for things to be exact or symmetrical   |

**For office use only:**

## MEDICAL EVALUATION QUESTIONNAIRE

Please answer this questionnaire by circling the appropriate responses.

PATIENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

CURRENT WEIGHT: \_\_\_\_\_ CURRENT HEIGHT \_\_\_\_\_

### Family Medical History

**Have any of your blood relatives suffered from the following diseases?**

High Blood Pressure	Yes	No	Kidney Disease	Yes	No
Heart Disease	Yes	No	Sickle Cell	Yes	No
Diabetes	Yes	No	Nervous or Emotional Problem	Yes	No
Cancer	Yes	No	Obesity	Yes	No
TB	Yes	No	Other _____	Yes	No

### Personal Medical History

**Do you have or have you ever had any of the following diseases or problems?**

Chicken Pox (varicella)	Yes	No	Epilepsy (fits)	Yes	No
Mumps	Yes	No	Parasites (intestinal worms)	Yes	No
Regular Measles (7 day)	Yes	No	Rheumatic Fever	Yes	No
German Measles (3 day)	Yes	No	Diabetes	Yes	No
TB	Yes	No	Cancer	Yes	No
Syphilis	Yes	No	Asthma	Yes	No
Gonorrhea	Yes	No	Ulcer	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No
Heart Trouble	Yes	No	Cataract	Yes	No
Back Problems	Yes	No	Gallstones	Yes	No
Broken Bones or Fractures	Yes	No	Chronic Pain	Yes	No
Thyroid	Yes	No	Lung Problems	Yes	No
			Other _____	Yes	No

**Have you had the following surgeries?**

Appendix	Yes	No	Heart or Blood Vessels	Yes	No
Gall Bladder	Yes	No	Lungs	Yes	No
Stomach	Yes	No	Hernia	Yes	No
Bowel or Intestine	Yes	No	Bones or Joints	Yes	No
Hemorrhoids	Yes	No	Kidney	Yes	No
Male or Female Organs	Yes	No	Other _____	Yes	No

**Are you taking any medications?**

Aspirin	Yes	No	Diabetic Medicine	Yes	No
Sleeping Pills	Yes	No	Water Pills	Yes	No
Nerve Pills	Yes	No	Blood Pressure	Yes	No
Pain Pills	Yes	No	Birth Control Pills	Yes	No
Heart Medicine	Yes	No	Other _____	Yes	No

**\*\*Note:** If you answer yes to any of the "medication" questions, please make sure to list them on page three (3) of the Comprehensive Patient Assessment Questionnaire.

**Personal Medical History**

**Women:**

Date of last menstrual period \_\_\_\_\_ Method of Birth Control \_\_\_\_\_

Is there any possibility that you are pregnant? \_\_\_\_\_ Are you considering pregnancy? \_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_ Date of last Mammogram \_\_\_\_\_

**For office use only:**



**Dr. Harold C. Urschel, III, MD, MMA**  
**Dr. Kevin Gilliland, PsyD**  
**Dr. Irina Gromov, MD, PhD**  
**Dr. Jeanie Zelanko, PMHCNS-BC, PhD**  
**Dr. Larry Hanselka, PhD**

## **NOTICE OF PRIVACY PRACTICES**

This notice describes how clinical information about you may be used and disclosed, your rights with regard to your protected health information, and our duties to protect such information. This Notice of Privacy Practices is effective beginning April 14, 2003. Please review it carefully.

### **I. INVOLUNTARY USES AND DISCLOSURES OF YOUR HEALTH INFORMATION**

How we may use and disclose your protected health information without your authorization:

1. We may disclose protected health information to your personal representative should you have one. If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, we must treat such person as a personal representative. If under state law a parent, guardian, or other person acting in loco parentis has authority to act on behalf of an individual who is an un-emancipated minor in making decisions related to health care, we must treat such person as a personal representative.
2. We will write, fill, and send prescriptions to covered entities or business associates.
3. We will provide protected health information to the Secretary in order for the Secretary to investigate issues and determine our compliance with federal privacy requirements.
4. We will disclose protected health information when we are required to do so by federal, state, or local law.
5. We may disclose protected health information for public health activities. For example, we may disclose protected health information to a public health agency to assist in an investigation of food poisoning. As another example, we may disclose protected health information to enable a public health agency to study diseases (e.g., cancer registries) or deaths of public health importance.

6. We may disclose protected health information for health oversight activities. For example, a health oversight activity may include the disclosure of protected health information in the course of an investigation of a provider's conduct to a state licensing board official.
7. We may use and disclose protected health information if it is necessary to avert a serious threat to the health or safety of the individual or others or to assist law enforcement authorities in identifying or apprehending an individual.
8. We may disclose protected health information to coroners, medical examiners, and funeral directors to assist them in identifying deceased persons, determining the cause of death, or other duties required for them by law.
9. We may report protected health information to government authorities if we have a reasonable belief that a situation involves abuse, neglect or domestic violence. We will abide by state law in making any disclosures involving abuse, neglect, or domestic violence.
10. We may release protected health information for judicial and administrative proceedings. Such proceedings would include responses to court orders or subpoenas.
11. We may disclose protected health information as required by military authorities if the individual is a member of the military. This would include releases for foreign military personnel. Additionally, we may disclose protected health information to federal officials for national security reasons as authorized by law.
12. We may disclose protected health information for law enforcement purposes if requested by a law enforcement official. For example, we may disclose protected health information if it would assist the law enforcement agent in locating a material witness to a crime.
13. We may disclose protected health information to assist local health partnerships established by law to plan and ensure health care services. For example, we may provide protected health information to assist the partnerships in identifying common diseases in a certain community and providing treatment to improve the health of the community.
14. We may provide protected health information in training programs in which staff, students, or trainees learn under supervision to practice or improve their skills as health care providers.
15. We may disclose protected health information when the use and/or disclosure relates to correctional institutions and/or other law enforcement custodial situations. For example, in certain circumstances, we may disclose protected health information to a correctional institution having lawful custody of an individual.
16. We may use and disclose protected health information in conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

17. Section 181 of Texas SB 11 allows use and disclosure of protected health information to covered entities for the processing of payments. It also allows a provider to disclose such information to non-profit organizations that pay for health care services or prescription drugs for an indigent person, as long as the agency's primary business is not the provision of health care or reimbursement for health care services.
18. In the event of an emergency where there are substantial barriers to communicating with you and we believe you intended for us to treat you, we may disclose relevant medical information in order to ensure that you receive proper care.
19. We may need to use any protected health information in your file for quality control purposes or any other administrative purposes to run our practice.
20. We may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, protected health information about treatment alternatives, or other health related information that may be of interest to you (i.e. test results).

## **II. VOLUNTARY USES AND DISCLOSURES OF YOUR HEALTH INFORMATION**

How we may use and disclose your protected health information with your authorization:

1. We may use and disclose your protected health information when we contact you for an upcoming appointment.
2. We will disclose protected health information when we make individual referrals for follow up treatment.
3. We may disclose protected health information for medical or health-related research. However, this type of disclosure, similar to some others in this category, will require that the recipient (i.e., researcher) ensure that protected health information will be protected and other requirements are met.
4. We may disclose protected health information for the purpose of processing and adjudicating workers' compensation claims.
5. We may disclose your protected health information to your family members or friends who are involved in your care or who assist you in paying for your care.

## **III. YOUR RIGHTS**

**Restriction on Release.** You may request that we not use or disclose your protected health information (1) for your treatment, payment, or the administration/management of our practice, (2) in notifying family members and friends of your condition or location, and (3) to family and friends involved in your care.

**Confidential Communications.** You may request that we communicate with you at a different location (e.g., at work rather than home) or in an alternative manner (e.g., using an envelope without the Institute's seal). We will try to accommodate your request provided that you specify the alternative contact or

method and pay any additional costs related to such requests.

**Access and Amendment.** In most cases, you have the right to inspect or receive a copy of your protected health information that we use to make decisions about you. Additionally, if you believe that your protected health information in your record is incorrect or if important protected health information is missing, you have the right to request that this protected health information be corrected or amended.

**Accounting.** You may request a limited list of instances where we have disclosed your protected health information. The list of disclosures includes only those disclosures occurring after April 14, 2003. Further, the list will not include disclosures: (1) for treatment, payment or related administrative/management purposes; (2) to you; (3) to friends/family involved in your care or payment for your care, or for notifying your family/friends in situations where you indicate that you agree to the disclosure; (4) under certain circumstances for national security or intelligence purposes; and (5) to correctional institutions or law enforcement officials having lawful custody of an inmate or protected health information about an inmate or individual, under certain conditions. Disclosures to health oversight agencies or law enforcement officials may be temporarily suspended if such disclosures delay the activities of the agency or official.

#### **IV. OUR DUTIES**

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by HIPPA guidelines and by the terms of the notice currently in effect.

We may apply a change in a privacy practice that is described in the notice to protected health information at any time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for protected health information. We will provide you with a revised notice upon request. Prior to making a material change in our privacy policies, uses and disclosures, or our legal duties, we will change our notice and post the new notice in the waiting area. The Notice of Privacy Practices will also be provided on our website.

#### **V. COMPLAINTS**

If you feel that your privacy rights have been violated, you may inform us by contacting our Office Manager at 214-890-6728. You may send a written complaint to the Secretary of the Department of Health and Human Services. We will not punish or retaliate against you for filing any complaints.

#### **VI. CONTACT US**

If you have any questions, please call our Practice Administrator at 214-890-6727.

I have read and have received a copy of the Notice of Privacy Practices from the Urschel Recovery Science Institute.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_