IMPORTANT:

Please print as **single-sided** sheets rather than double-sided.

Thank you

WELCOME PACKET

Welcome to Fairweather Medical Group! We feel privileged that you have chosen to come to us for help. Dr. Fairweather, her Physician Assistants, and the entire Fairweather Medical Group team are fully dedicated to providing you with compassionate psychiatric care of the highest quality, and doing so in an environment that feels safe and comfortable.

We are a collaborative physician/physician extender practice:
This means that our providers—Dr. Fairweather and her Physician Assistant, Ms. Workman—work together to afford you more timely appointment scheduling, additional time with your provider if needed, and different price points for services.

We are a fee-for-service practice:
We do not accept any form of medical insurance, Medicaid, or Medicare. And given that you're paying out of pocket for our services, we believe that you have the right to choose your provider; thus, if for any reason you have been assigned a provider who seems not to be an ideal fit for you, simply notify staff, and we will do our best to correct the situation.

This is a partnership—one between your provider and you.
We're excited to partner with you, with the ultimate goal of you feeling and functioning at your very best. We encourage you to ask questions of providers and staff, as well as providing feedback on your interactions with staff and providers, how your treatment is progressing, and your overall experiences with us—both good and bad. The more feedback you provide, the better we can tailor your treatment and your experience to best serve you.

Please keep in mind that disagreements may arise in this provider-patient partnership. Patients sometimes don't understand the reasoning behind our decisions, despite our efforts to be transparent and provide explanations. Know that your treatment plan will always be based on your provider practicing medicine as the Hippocratic Oath requires: Our primary duty to you is not to harm you. Our secondary duty is to help you. Abiding by this oath may at times require us to provide different treatment(s) than you want, or to withhold desired treatment(s), and it is the most common source of misunderstandings between provider and patient. Remember, we put your safety and well-being over all else, including whether or not you're displeased with us.

Wait Times:
We do our best to stay on schedule, and we leave space in the schedule for surprises and emergencies; however, psychiatry is unpredictable, and there are days when the surprises and urgencies (e.g., patients unexpectedly needing more than the allotted 15 minutes) outpace the time we've allotted for them. On these days, we're likely to run late. If you're ever in our waiting room longer than you'd like, please remember that you, too, will be afforded extra time and attention should the need ever arise, even if it means putting the entire clinic behind. Although we do value your time, we prioritize thorough, compassionate care over all else.

Some patients cannot understand why they have to allow their provider to run late, while they are not allowed to arrive late for their appointment time without rescheduling their appointment. While this may appear unfair on the surface, here is our reasoning: We're often teetering on running late due to unexpected, additional needs of patients throughout the day; if we also allow patients to arrive late for their

appointments, the problem would be compounded, and we would most certainly run late—very late—virtually every day. Please understand that we're doing our best for each of you.

ADHD Patients:
Once you're stable on medication and are visiting the clinic less than monthly, you will need to get your ADHD medication refilled between visits. Stimulant medications for ADHD are highly regulated, and there is no way to write a refill on a stimulant prescription. Instead, we will have you go to a website, ReScriptMe.com, to request and pay for your refills on ADHD medications between visits. We charge for this service because much manpower goes into researching, preparing, documenting, and providing these refills, especially given the stringent regulations on monitoring patients taking these medications, as well as on writing these medications. We feel a fee is a good tradeoff, as many providers who prescribe stimulant medications require patient to be seen each month in order to get a stimulant refill. This seems unnecessary to us, so we've structured visits and refills as we have. Due to stringent DEA regulations and monitoring of providers who write stimulant prescriptions, patients taking these medications must follow-up with us no less than every three months, and must submit to random drug screens.

Bringing Children to Visits:
We discourage this. We are not anti-kids; however, children can be a tremendous distraction to both provider and patient when brought to visits. Also, we often have patients in the waiting room who cannot tolerate being around active, loose children without becoming highly anxious, agitated, or overwhelmed. We have some patients who are paranoid, hearing voices, and/or seeing things, and these individuals could become easily agitated and unpredictable around active children.

For these reasons, we do not allow children under 12 to be left unattended in the waiting area, as our staff hasn't the time or ability to watch them for you. Toddlers must remain strapped in their strollers at all times, and mobile children cannot be allowed to roam the waiting room—they must remain seated next to you. We do not allow more than 2 children per patient in the waiting area. And please do not allow children (or yourself ☺) to eat or drink—other than water—on our premises. We worked hard to build a facility that is clean and tidy, and we've had children, with their food and/or drinks, cause us to have to reupholster furniture, repaint walls, and have the carpet cleaned; our restrictions regarding children, and regarding food/drink on the premises (for both children and adults) arose from those experiences. If you're unable to find childcare, you may want to consider telepsychiatry for some of your clinic sessions if your provider deems this an option for you.

Providing Feedback:
If we've helped you and you're pleased with us, please share your experiences on Google + and other physician rating sites. If you have a negative experience, however small, please share that with us as soon as possible. Because providers are busy seeing patients, and staff is busy in the front office, problems may occur unnoticed unless we can count on you to provide feedback. It is important to us that your experience with us is nothing less than phenomenal. If it isn't, your feedback will help us get there with you, as we'll always do our best for you.

What To Expect:

Be sure all paperwork is fully completed prior to your arrival, as the paperwork is comprehensive, and completing it may take between 30-60 minutes. Please do not leave anything blank, and where descriptions are called for, please provide as much detail as possible. Should you arrive late, or with incomplete paperwork, your initial evaluation will need to be shortened or rescheduled.

Your initial evaluation will be 45-60 minutes in length. For more complex cases your provider may need additional time in order to complete your evaluation, in which case you will be asked to return for another appointment in order for your provider to do so. Seeing you for an evaluation—even if treatment is initiated during that time—does not guarantee that we will take you on as a patient once the evaluation has been completed. Infrequently, after the completion of the initial assessment, we discover that a patient is not a good fit for our clinic. This policy is in your best interest, as we only treat that with which we have extensive experience. If you're referred to another provider after your evaluation, this is not personal—It's about ensuring that you receive the most appropriate treatment for your specific situation/conditions. Once the evaluation has been completed, if your provider asks you to return for additional visit, it is implied that you've been accepted into the practice as a patient

Follow-up visits are typically 15 minutes in length; although if you need additional time, we can often extend the length of your session. You'll be seen more frequently initially, to allow us to find the best course of treatment, and to closely monitor your progress. Once your treatment regimen is stable, and if you're sufficiently well, your provider will ask you to come for visits less and less frequently. Bear in mind, though, that if you are being prescribed certain medications, you may have to be seen more frequently, and any time a medication change (type or dosage) is initiated, you'll typically be asked to return in one month to follow up on your response to the change. In recommending follow-up dates, we try to remain within general guidelines for visit frequency given your particular diagnosis/diagnoses, medications, medical conditions, and level of stability. Our providers prefer to involve you in decisions regarding your treatment. We do this by educating you about your treatment options, and guiding you as to which might be best based on our knowledge and experience, combined with your opinions and preferences. If, however, you're one who would rather simply be advised as to how to proceed with treatment, we will still educate you, but we will do our best to accommodate you.

If you have any questions at this point, feel free to reach out to us via our patient portal—this is the quickest way to get a response, and you can do so by using the form that appears on the right-hand side of each page of our website). You may also call us at (817) 283-3400.

Thank you, and welcome!

PATIENT REGISTRATION

PATIENT INFORMATION:

NAME _____

NICKNAME/PREFERRED NAME _____

DOB_____ SS# _____

ADDRESS _____

CITY _____STATE ____ ZIP CODE _____

DRIVER'S LICENSE: STATE ____ NUMBER _____

INSURANCE ID# *_____

* We do not accept insurance; however, this information may be needed for prescription authorization purposes.

CONTACT INFORMATION:

CELL _____ WORK _____

HOME _____ OTHER _____

EMAIL _____

Please indicate any phone numbers on which we may not leave messages. All numbers listed will be sent a text appointment reminder for each visit.

EMERGENCY CONTACT:

NAME _____

RELATIONSHIP TO PATIENT _____

PHONE #S _____

EMAIL _____

REFERRED BY:

INTERNET SEARCH:

GOOGLE, YAHOO, BING, OTHER: _____

PHYSICIAN RATING SITES:

GOOGLE +, RATEMDS, VITALS, HEALTHGRADES, YELP

PHYSICIAN/THERAPIST _____

PHONE, FAX AND/OR EMAIL: _____

_____

OTHER: _____

PHARMACY INFORMATION:*

WE ENCOURAGE YOU TO USE PHARMACIES OTHER THAN WALGREENS AND CVS— THESE PHARMACIES CONSISTENTLY MAKE ERRORS IN FILLING OUR PRESCRIPTIONS—HOWEVER, WE WILL E-PRESCRIBE YOUR MEDICATIONS TO ANY PHARMACY YOU CHOOSE.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: _____

••••••••••••••••••••••••••

PLEASE NOTIFY US PROMPTLY OF ANY CHANGES IN YOUR INFORMATION.

••••••••••••••••••••••••••

DATE COMPLETED: _____

CHECKED FOR UPDATES: _____, _____

_____, _____, _____, _____

Patient Age _____ **Date of Appointment** _____

Please explain briefly why you are here, and describe what you would most like to accomplish at this visit.

_____
_____
_____
_____

Current Psychiatric Medications: (You will be able to list other medications later.)

Medication / Strength	# times/day	Start Date	Effective?	Side Effects?

Past Psychiatric Medications:

Medication/Strength (mg)	Age(s) Taken & for How Long?	Reason(s) Discontinued

Medication Allergies:

Medication	Reaction

Women:

Date of Last Menstrual Period: _____ Do you use birth control? Y / N

Type of Birth Control used: _____ Prescribing Physician: _____

Are you currently pregnant, or is there a chance you might be pregnant? Y / N

Have you ever been sexually active? Y / N Are you currently sexually active? Y / N

Have you had a tubal ligation or hysterectomy? Y / N

If your partner is a male, has he had a vasectomy? Y / N

Medical Illnesses & Medications: (Please also include supplements, vitamins, OTC meds, etc.)

Medication / Dose	Illness / Disease	Prescribing Physician

FAMILY PSYCHIATRIC HISTORY:

Please list blood relatives who have a diagnosis (confirmed or suspected) of the following mental illnesses. If you know the names of their psychiatric medications, please list those as well.

ADD / ADHD _____
Anxiety _____
Depression _____
Bipolar Disorder _____
OCD / Phobia _____
Social Anxiety _____
Schizophrenia _____
Eating Disorder _____
Alcohol Abuse _____
Drug Abuse _____
Suicide Attempt _____
Institutionalization _____

Substance Use:

Do you, or have you ever, used alcohol, illicit drugs, non-prescribed drugs/medications, or have you ever abused prescribed drugs? Y / N If yes, please complete pages 3 and 4 (Alcohol and Drug History).

ALCOHOL AND DRUG HISTORY: Please complete the table below

1	2	3	4	5	6	7	8	9	10
Substance: * Do not include prescribed medications *unless* you used them above recommended levels, abused them, or used them outside of their intended use or effect.	**RouteTaken** (e.g., sniffed, ate, smoked, IV use)	**Age at First Use**	**Following your first use, what was your regular use pattern?** (frequency, quantities, bingeing, and/or using in increasing amounts) **Please list approximate ages (or dates) for these time periods.**	**Age or Date of Last Use** of this/these substances.	**Most recent use pattern:** (frequency, quantities, bingeing, and/or using in increasing amounts) **Please list approximate ages (or dates) for these time periods.**	**Duration of pattern described in Box 6:**	Have you at any time developed either **tolerance to,** or **withdrawals from,** this (these) substance(s)?	**Have you had any clean periods from this substance?** If so, when and how long?	**Do you have any desire to reduce or eliminate the use of this substance?**
Alcohol									
Cannabis									
Opiates (pain pills, heroin)									
Powder Cocaine									
Crack Cocaine									
Methampheta-mine, Ice									
Adderall, Ritalin									
Xanax, Valium, Klonopin									
"Triple Cs"									

1	2	3	4	5	6	7	8	9	10
Substance	**RouteTaken** (e.g., sniffed, ate, smoked, IV use)	**Age at First Use**	**Following your first use, what was your regular use pattern?** (frequency, quantities, bingeing, and/or using in increasing amounts) **Please list approximate ages (or dates) for these time periods.**	**Age or Date of Last Use** of this/these substances.	**Most recent use pattern:** (frequency, quantities, bingeing, and/or using in increasing amounts) **Please list approximate ages (or dates) for these time periods.**	**Duration of pattern described in Box 6:**	Have you at any time devel-oped either **tolerance to,** or **withdrawals from,** this (these) substance(s)?	**Have you had any clean periods from this substance?** If so, when and how long?	**Do you have any desire to reduce or eliminate the use of this substance?**
Ecstasy, Eve, Molly									
LSD, Mushrooms									
Ketamine									
Incense									
Bath Salts									
GHB									
Anabolic Steroids									
Huffing (specify substance)									
Other (Please specify)									

Alcohol and Drug History, Cont.

Regarding your previous answers:

1. Why do you think you use these substances?

2. Where do you get the money to purchase your drugs or alcohol?

3. Have you resorted to stealing, dealing drugs, or other illegal activities to fund your use?

4. Have you experienced negative consequences due to your use in any of the following areas? Please describe.

   Legal:

   School or work:

   Personal (relationships):

   Health:

   Financial:

   Other:

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Patient Self-Report for Adult ADD / ADHD

What led you to seek an evaluation at this time?

_____

_____

_____

_____

INATTENTION

When I Was Young, I:

Often failed to give attention to careless mistakes.	☐ Yes	☐ No
Often had difficulty sustaining attention in tasks/play (easily distracted).	☐ Yes	☐ No
Often did not seem to listen when spoken to.	☐ Yes	☐ No
Often did not follow through on instructions and failed to finish tasks.	☐ Yes	☐ No
Often had difficulty organizing tasks/activities (poor time management).	☐ Yes	☐ No
Often avoided tasks requiring sustained mental effort (e.g., homework).	☐ Yes	☐ No
Often lost things necessary for tasks (misplaced things).	☐ Yes	☐ No
Often got distracted by extraneous stimuli (difficulty finishing tasks).	☐ Yes	☐ No
Often was forgetful.	☐ Yes	☐ No

Currently, I:

Often fail to give attention to careless mistakes.	☐ Yes	☐ No
Often have difficulty sustaining attention on difficult, tedious, or boring tasks.	☐ Yes	☐ No
…I might even avoid aforementioned tasks altogether.	☐ Yes	☐ No
Often do not seem to listen when spoken to.	☐ Yes	☐ No
Often do not follow through on instructions and fail to finish tasks	☐ Yes	☐ No
Often have difficulty organizing in preparation for projects.	☐ Yes	☐ No
Often underestimate the time needed to complete tasks, resulting in frequent episodes of running late.	☐ Yes	☐ No
Often avoid tasks requiring sustained mental effort.	☐ Yes	☐ No
Often procrastinate.	☐ Yes	☐ No
Often misplace essential items.	☐ Yes	☐ No
Often get distracted by extraneous stimuli.	☐ Yes	☐ No
Often forget things.	☐ Yes	☐ No
Often must read things more than once to retain the material.	☐ Yes	☐ No

HYPERACTIVITY & IMPULSIVITY

When I Was Young, I:

Often squirmed in my seat, and/or fidgeted with my hands or feet.	☐ Yes	☐ No
Often left my seat in the classroom or at the meal table.	☐ Yes	☐ No
Often ran about or climbed excessively in inappropriate situations (felt overwhelmed).	☐ Yes	☐ No
Often had difficulty playing quietly (self-selected active activities).	☐ Yes	☐ No
Often felt “on the go” or “driven by a motor.”	☐ Yes	☐ No
Often talked excessively.	☐ Yes	☐ No
Often blurted out answers before questions were completed.	☐ Yes	☐ No
Often had difficulty waiting my turn.	☐ Yes	☐ No
Often interrupted or inappropriately intruded on others.	☐ Yes	☐ No

Currently, I:

Often fidget with my hands or feet, shake my leg(s), click or flip pens, and/or pick at my hands or nails.	☐ Yes	☐ No
Often find it difficult not to leave my seat in class, meetings, or at dinner.	☐ Yes	☐ No
Often have difficulty unwinding and relaxing…I do better when I’m on the go.	☐ Yes	☐ No
Often talk excessively in social or work situations.	☐ Yes	☐ No
Often blurt out answers before questions are completed and/or interrupt frequently.	☐ Yes	☐ No
Often make impulsive decisions about spending, changing jobs, and other tasks that really should be planned.	☐ Yes	☐ No
Often become impatient when I have to wait.	☐ Yes	☐ No
Often get frustrated easily.	☐ Yes	☐ No
Often drive fast or recklessly due to my impatience.	☐ Yes	☐ No

AGE OF ONSET OF ADD / ADHD SYMPTOMS: Now that you have had a chance to recall your childhood symptoms, at what age do you (or a parent or sibling of yours) recall first having ADD / ADHD symptoms?

☐ 0 - 7 years
☐ 8 - 12 years
☐ 13 - 15 years
☐ 16 - 21 years
☐ 22 – present

PRIOR ADD / ADHD HISTORY:

Have you previously been evaluated for ADD / ADHD? ☐ Yes ☐ No
If so, at what age? _____ Did you undergo formal psychological testing? (Generally performed on a computer) ☐ Yes ☐ No
What entity or provider performed this testing? _____ Phone: _____
Were you treated? If so, with what medication(s)? _____
_____
_____

SCHOOL PERFORMANCE FROM PRE-SCHOOL TO PRESENT:

Describe any trouble starting school. Did you repeat any grades? Were you in any special classes? How would you describe your grades throughout your education? How were your conduct grades? Did your teachers think you were performing up to your potential? How were you with getting homework and projects turned in? Did you often daydream in class? Did you have any trouble comprehending what the teacher was saying? Did you get in fights? Were you ever suspended from school?

_____
_____
_____
_____
_____
_____

LIFE FEATURES:

Describe any problems you've had with the law; troubles with driving (tickets, accidents, neglecting maintenance); frequent changing of jobs or career paths; bills not being paid on time; losing important things; poor performance at school and/or work; allowing mail or papers to pile up; problems socially due to interrupting or not listening during conversations; any depression or anxiety resulting from problems stemming from untreated ADD/ADHD.

_____
_____
_____
_____
_____
_____

WHAT ARE YOUR MOST PRESSING CONCERNS IN EACH AREA REGARDING YOUR UNTREATED ADD / ADHD SYMPTOMS?

School: _____

Work: _____

Home: _____

Social / Friends / Family: _____

Other: _____

Authorization for Release of Protected Health Information

Patient: _____ Date of Birth _____

I hereby authorize Lisa Fairweather, D.O. and her associates to send information to and receive information from the following entities:

(Please be sure to list your previous Psychiatrist, your primary care physician, your counselor/therapist, family member(s), and any other persons or entities with whom you Dr. Fairweather and her associates to communicate.)

Name: _____ Phone: _____
Relationship: _____ Fax / Email: _____

Name: _____ Phone: _____
Relationship: _____ Fax / Email: _____

Name: _____ Phone: _____
Relationship: _____ Fax / Email: _____

Name: _____ Phone: _____
Relationship: _____ Fax / Email: _____

Information to be Released, and Applicable Dates of Service

If records are 20 pages or more, please mail them to: **4016 Gateway Dr. #120 Colleyville, TX 76034**

If records are less than 20 pages, please fax them to: **817-283-4306**.

☐Mental Health Records From _____ to _____ or ☐ALL

☐Drug and Alcohol Treatment Records From _____ to _____ or ☐ALL

☐HIV/AIDS-Related Information From _____ to _____ or ☐ALL

☐Other: _____ From _____ to _____ or ☐ALL

Date(s) Records Requested from above Entity: _____

This authorization will not expire unless a specific expiration date or condition is named here:_____. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this authorization for Release of Protected health Information and authorizing the disclosure is voluntary. I understand I may inspect the information to be used or disclosed, as provided in CFR 186.524.

I, the undersigned, having read the above and authorized the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be withdrawn by me at anytime except to the extent that action has been taken in reliance upon it. I acknowledge that the material authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR pts. 160 and 164 and the Health Insurance Portability and Accountability Act of 1996, 45 space cf. our space. This facility is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this "Authorization for Release of Protected Health Information."

Patient Signature: _____ Date: _____

Fee Schedule — All fees are non-refundable, except in cases of error on our part.

Payment is due at the time of service. Any remaining balance (e.g., if session duration is extended, if random drug screen is performed, etc.) will be due at the time of checkout.

Physician Assistant ("PA") Fee Schedule

Initial Visit	45 – 60 min	$350
Initial Visit—After-Hours / Emergency	45 – 60 min	$500
Follow-Up	up to 15 min	$120
	16-22 min	$180
	23-30 min	$240
After-Hours Follow-Up	1 - 15 min	$160
	16-22 min	$200
	23-30 min	$240
Telemedicine Follow-Up	15 min	$200
	16-22 min	$260
	23-30 min	$320

Physician Fee Schedule

Initial Visit	45 – 60 min	$450
Initial Visit—After-Hours / Emergency	45 – 60 min	$600
Follow-Up	up to 15 min	$170
	16-22 min	$255
	23-30 min	$340
After-Hours Follow-Up	1 - 15 min	$210
	16-22 min	$250
	23-30 min	$290
Telemedicine Follow-Up	15 min	$250
	16-22 min	$310
	23-30 min	$370

ADHD Medication Refills Between Visits	$35[A, B]
Injection-Only Appointment	$50
Drug Screen	$90
Laboratory Confirmation of a positive drug screen (uninsured patients)	$110
Prior Authorization Appeal:	$50

Completion of paperwork, per patient request
—Billed at the same rate as follow-up sessions:
$120 per 15-minute increment of time (PA)
$170 per 15-minute increment of time (physician)

Phone call with a provider
—Billed at the same rate as follow-up sessions:
$120 per 15-minute increment of time (PA)
$170 per 15-minute increment of time (physician)

[A] Requests for between-visit ADHD medication refills (no other medications) are made via the ReScriptMe.com website. Prior to submitting your refill request, ensure that you are, in fact, due for a refill within the 5-10 days subsequent to your request—payments made on the ReScriptMe site are non-refundable.

[B] If you have an upcoming appointment, please do not submit an ADHD medication refill request through ReScriptMe unless you need a partial refill to last until your appointment—Your medications will be refilled at your appointments, as appropriate.

No-Show or Late-Rescheduling[C] of a New Patient Appointment
Forfeiture of $200 deposit.

[C] (When notice is not provided to us at least 48 hours prior to the start time of the appointment, excluding weekends and holidays.)

No-Show or Late-Rescheduling[D] of a Follow-Up Appointment
Full session fee is charged to your credit card on file. (e.g., If you miss a 15-minute follow-up with the physician, $170 is due; if you schedule a 30-minute follow- up with the PA, $240 is due.)

[D] (When notice is not provided to us at least 24 hours prior to the start time of the appointment, excluding weekends and holidays.)

Paying for routine charges by using a credit card on file (as opposed to providing us with a physical card): a 3% fee will be added to the total amount to cover our expense. (This does not apply to charges for telemedicine visits.)

Use of more than one credit card for a single charge: 3% of the larger of the amounts charged to additional card(s)

Past-due balances: Unless otherwise agreed upon, late fees will accrue at $5 per 7 calendar days beginning 7 calendar days after the due date. All past-due balances must be paid in full prior to receiving medication refills or scheduling an appointment.

Returned checks will result in a $35 fee, which will be charged to your credit card on file.

Your signature below indicates that you understand the above and agree to pay all applicable charges as described herein.

_____ _____ _____ Copy to Patient ☐ _____Staff Initials

Patient Printed Name | Patient Signature | Date

Telepsychiatry Informed Consent

Patient Name: _____ Date of Birth:_____

Location(s) of Patient during conduction of telepsychiatry sessions (City & County are required for each location in Texas*); these can be added as necessary

** By law, the patient must physically be in the state of Texas for all telepsychiatry sessions, as that is considered to be the location where the session is conducted.*

City	Tx County		City	TX County		City	TX County
1.	1.		3.	3.		5.	5.
2.	2.		4.	4.		6.	6.

Introduction

Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using audio and/or video interfaces such as telephone conversations and videoconferencing. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits of Telepsychiatry

- Improved access to psychiatric care by enabling patients to receive psychiatric care at times when they might not be able to be physically present in the provider's office.
- Telepsychiatry is often a more efficient psychiatric evaluation and management tool than are in-person visits.
- Obtaining the expertise of a distant specialist.
- Allows for patients who live a long distance away from the clinic to remain with their provider, as they only need to come to the clinic for in-person visits every 6 to 12 months, depending on the medications they're taking, and on their psychiatric stability.

Possible Risks of Telepsychiatry

As with all electronic transmission of health information, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s); if this is the case, you will be notified and asked to come to the clinic for an in-person session.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgmental errors.

By signing this form, I understand the following:

1. The laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no personal information obtained in the use of telepsychiatry will be disclosed to other entities without my consent.
2. I have the right to withhold or withdraw my consent to the use of telepsychiatry at any time in the course of my care, without affecting my right to future care or treatment.
3. I have the right to inspect all information obtained in the course of a telepsychiatry interaction (unless my provider believes doing so would be harmful to me), and that I may receive copies of this information for a reasonable fee.
4. Alternative methods of psychiatric care are available to me, and that I may choose one or more of these at any time if I do not want to participate in telepsychiatry.
5. It is my duty to inform my provider of all other healthcare providers involved in my medical/psychiatric care, as well as all other medications (both prescribed and over the counter) and supplements that I take, and that I must inform my provider at each visit if any of the above have changed since my last session with my provider.
6. I may expect the anticipated benefits from the use of telepsychiatry in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my psychiatrist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care.

Patient Signature: _____ **Date:** _____

CONSENT FOR TREATMENT

I voluntarily agree to receive medical/psychiatric services from Fairweather Medical Group by Lisa Fairweather, D.O., and her Physician Extenders and Staff. I agree to actively participate in my treatment plan, and to take prescribed medications as directed by my provider. As part of my treatment, I agree to disclose all medications from other providers at each visit and I agree to allow Dr. Fairweather and staff electronic access to medications prescribed to me by other physicians.

I realize that I may discontinue treatment and/or withdraw my consent to treatment at any time.

I understand that being evaluated by Dr. Fairweather or a Physician Extender does not constitute a doctor-patient relationship; this relationship only commences if my provider agrees to do so after fully completing a comprehensive psychiatric evaluation.

I have read and understand the information provided in this document.

Print Name:_____ DOB: _____

Signature:_____ Date:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Policies for Fairweather Medical Group P.A., and I have been provided an opportunity to review and ask questions pertaining to this form. I am signing this Voluntarily.

Print Name:_____ DOB: _____

Signature:_____ Date:_____

Notice of Privacy Policies for Fairweather Medical Group P.A.

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.

Information about you is obtained as a record of your contacts and visits for healthcare services from Lisa Fairweather, D.O., her Physician Extenders, and staff, as well as information collected about you between visits. This information is called protected health information ("PHI"). Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Lisa Fairweather, D.O., her Physician Extenders, and staff are required to follow specific rules on maintaining the confidentiality of your PHI, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control you PHI. It also describes how we follow those rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our health care operation and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of you rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Policies. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you, or you may download the latest copy from our website at https://www.doctorlisafairweather.com/help/.

You have the right to authorize other use and disclosure. This means you have the right to authorize or deny any other use or disclosure of PHI not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to authorize a personal representative. This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of PHI.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in your patient record. In certain cases, we may deny your all or part of your request.

You have the right to request a restriction of your PHI. This means, you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.

You may have the right to request an amendment your PHI for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability. This means that you may request a listing of your PHI disclosures we have made to entities or persons outside of our office.

How We May Use or Disclose PHI

Following are examples of use and disclosures of your protected health care information that we are permitted to make. Theses examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For treatment- We may use and disclose your PHI to provide coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment, including pharmacies, insurance companies, and other providers who may be involved in your care and treatment.

We may also call you by your first name in the waiting room when your provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For payment- Your PHI will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations- we may use or disclose, as needed, your PHI in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It
When an Inmate. We may disclose your PHI if you are an inmate of a correctional facility and your provider created or received your PHI in the course of providing care to you.

Required Uses and Disclosures. Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Questions or complaints about this notice should be directed to:
Fairweather Medical Group, Attn: Compliance Dept.
4016 Gateway Dr. #120 Colleyville, TX 76034 Phone: 817-283-4300
https://www.doctorlisafairweather.com/help/

If you think we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you the address to file your complaint with this Department. We will not in any way retaliate if you choose to file a complaint.