IMPORTANT:

Please print each page as a **single-sided** sheet rather than double-sided and complete the forms in their entirety prior to your appointment time.

Thank you

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:_____

Patient Registration

Patient Information:

Name _____

Nickname/Preferred Name _____

DOB _____ SS# _____

Address _____

City, State, Zip _____

Do you have prescription coverage? Y / N

Name of insurance company _____

Contact Information:

Please indicate clearly if you would not like messages left at any of the contacts listed below.

Cell _____ Alt. _____

Home _____ Work _____

Email [1] _____

Skype _____

Other _____

Unless otherwise indicated, we will assume that information may be left at all contact points provided at any time during the course of your treatment at this clinic.

[1] *Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.*

Preferred Method of Contact for Courtesy Reminder Calls: You may select multiple methods if you prefer.

☐ Text ☐ to cell phone provided
☐ to (_____) _____ - _____

☐ Email ☐ to email provided
☐ to _____

☐ Phone Call to (_____) _____ - _____

Please notify us promptly of any changes in your information. Thank you!

Pharmacy:

Name _____

Street Address _____

City _____

Phone _____

All prescriptions will be sent to your pharmacy electronically; therefore, we need complete pharmacy information in order to provide you with prescriptions.

Referral Information:

Internet Search:

☐ Google ☐ Yelp ☐ Health Grades ☐ Vitals
☐ Rate MDs ☐ Other _____

Physician/Therapist _____

Phone _____

Other _____

Emergency Contact:

Name _____

Relationship to Patient _____

Contact Information _____

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

Regarding my Protected Health Information ("PHI"): I hereby authorize Dr. Lisa Fairweather and her Nurse Practitioners to **receive my PHI from** and **release my PHI to** the person(s) and/or facilities listed below.

*Patients, please complete only the greyed areas. Your provider will assist you with the remainder of the form during your session. Thank you.

Patient Name: _____	Date of Birth: _____
PRIMARY CARE PHYSICIAN / OB-GYN	PURPOSE OF RELEASE OF PHI:
Physician Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____	☐ Continuity of Medical Care ☐ Legal Matter ☐ Personal ☐ Other: _____

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**.

☐ Progress Notes	From _____ to _____	or ☐ ALL
☐ Labs Only	From _____ to _____	or ☐ ALL
☐ Genetics Test Results	From _____ to _____	or ☐ ALL
☐ Medication History	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 Confidential 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, have read the above and authorize 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 any time except to the extent that action has been take 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 Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 CFR pts.160 and 164. This facility is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this "Authorization for the Release of Protected Health Information."

Patient Signature: _____ Date: _____

Authorization for Release of Protected Health Information

Regarding my Protected Health Information ("PHI"): I hereby authorize Dr. Lisa Fairweather and her Nurse Practitioners to **receive my PHI from** and **release my PHI to** the person(s) and/or facilities listed below.

*Patients, please complete only the greyed areas. Your provider will assist you with the remainder of the form during your session. Thank you.

Patient Name: _____	Date of Birth: _____
PREVIOUS PSYCHIATRIST	PURPOSE OF RELEASE OF PHI:
Physician Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____	☐ Medical Care ☐ Legal Matter ☐ Personal ☐ Other: _____

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
☐ Labs Only	From _____ to _____	or ☐ ALL
☐ Genetics Test Results	From _____ to _____	or ☐ ALL
☐ Medication History	From _____ to _____	or ☐ ALL
☐ Psychiatric Admit/Discharge Summaries	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 Confidential 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, have read the above and authorize 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 any time except to the extent that action has been take 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 Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 CFR pts.160 and 164. This facility is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this "Authorization for the Release of Protected Health Information."

Patient Signature: _____ Date: _____

Authorization for Release of Protected Health Information

Regarding my Protected Health Information ("PHI"): I hereby authorize Dr. Lisa Fairweather and her Nurse Practitioners to **receive my PHI from** and **release my PHI to** the person(s) and/or facilities listed below.

*Patients, please complete only the greyed areas. Your provider will assist you with the remainder of the form during your session. Thank you.

Patient Name: _____	Date of Birth: _____
COUNSELOR/THERAPIST	PURPOSE OF RELEASE OF PHI:
Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____	☐ Continuity of Care ☐ Legal Matter ☐ Personal ☐ Other: _____

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 Confidential 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, have read the above and authorize 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 any time except to the extent that action has been take 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 Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 CFR pts.160 and 164. This facility is released and discharged from any liability and the undersigned will hold the facility harmless for complying with this "Authorization for the Release of Protected Health Information."

Patient Signature: _____ Date: _____

Clinic Policy

Please read carefully, then sign and date at the bottom. *Feel free to ask any staff member for help if you have questions regarding our policies—We will be more than happy to assist you!*

1. The initial visit will be 30 – 60 minutes, depending on the complexity of your case. Follow-up visits are 15 minutes in duration. Payment is due at the time of services.
2. Please make every effort to make appointment changes or cancellations at least 24 hours prior to the scheduled appointment time (72 hours in the case of Monday appointments). Failure to do so will result in a late-reschedule/no-show fee (see document entitled "Fee Schedule" for details). This applies irrespective of receipt of a courtesy reminder call regarding appointment time.
3. After two missed appointments without prior notification as described above, this clinic may no longer provide you with psychiatric services and may refer you to another provider.
4. If you have not been seen by your provider at this clinic within 60 days of the recommended follow-up date, you may no longer be considered a patient of this clinic and the doctor-patient relationship may be considered terminated at that time; however you are welcome to resume care with this clinic at any time thereafter at our discretion.
5. Please make every effort to be on time for your visit, as arriving late may necessitate either shortening or rescheduling of your session. This policy is in place so that the physician can stay on time, keeping your wait times at a minimum. If the session must be rescheduled due to late arrival, you may be charged a late reschedule fee as outlined above.
6. Medication changes require an appointment to see the provider; they will not be made between clinic visits.
7. Prescriptions are provided only during scheduled clinic visits,* at which time prescriptions are written with sufficient refills to ensure that you will have enough medication to last until your next recommended follow-up visit.

   * An exception is prescriptions for ADHD stimulant medications (e.g., Adderall, Ritalin, Vyvanse, etc.). These prescriptions do not have refills and are filled between clinic visits.
8. We do not honor pharmacy-initiated refill requests. In the event that a refill between clinic visits is needed, you need to call the clinic directly to request the refill.
9. If your provider, your pharmacist, or any current or past physician has reason to believe that you are in any way misusing medication issued from this clinic, including taking higher than the prescribed dose or obtaining duplicate medications from other physicians, this clinic may immediately stop providing you with treatment and refer you to another provider or to an emergency room for follow up care.
10. Random drug screens may be performed at the discretion of the provider. The cost of these screens is the responsibility of the patient. (See document entitled "Drug Screen Policy" for details.)
11. If you start new medications at any time during the course of treatment at this clinic, they may initially impair your driving skills; therefore, you should not drive or operate heavy machinery until you have had a chance to fully acclimate to all new medication(s).
12. For females of childbearing age: I am not pregnant and do not plan to become pregnant. I will notify the clinic immediately of any possibility of pregnancy, as many medications taken during pregnancy are associated with serious risks to the fetus.
13. Our Notice of Privacy Practices documentation is available upon request. Please inform a staff member if you would like a copy.
14. Unless otherwise indicated, your signature below confirms that you understand and agree to each paragraph above.

Patient Printed Name	Signature	Date

Fee Schedule

1. All payments are due at the time of services. Any remaining balance(s) will be due at the time of checkout.

2. The initial visit is generally 60 minutes in length, depending upon the complexity of your case. The fee for the initial appointment is $450 with $200 required at the time of booking and the remaining $250 due on the day of your first visit.

3. Follow-up (medication management) visits are scheduled at 15-minute intervals.
   The fee for follow-up visits is $120.

   If your session runs longer than the allotted time, or if you request a phone or emergency appointment, the following rates apply:

Session Duration	In-Person	Phone or Skype	Emergency
30 minutes	$250	$200	$350

   If you know in advance that you will need a longer session, please notify us as soon as possible. We value your time, and this will help us stay on schedule.

4. Fees for office visits are nonrefundable once the provider has conducted the visit, independent of the outcome of the visit(s).

5. Failure to make timely appointment changes or cancellations (see document entitled "Clinic Policy," Item 2) will result in a $120.00 late-reschedule/no-show charge to the credit card you have designated to be kept on file with our office. These charges are nonrefundable, except in cases of error on our part.

6. Fees are assessed for completion of any additional paperwork.

7. The refill fee for medications is $30 between follow-up appointments.

8. There will be a $35 nonrefundable fee assessed for returned checks.

10. Your signature below confirms that you understand and agree to each item above.

Patient Printed Name	Signature	Date

Drug Screen Policy and Fees

To ensure a more comprehensive understanding of your overall health picture, we are implementing a *random drug screen policy for all patients who are being prescribed controlled substances* (e.g., some ADHD, anxiety, and sleep medications). This policy also ensures compliance with the recent increases in DEA regulations of physicians who prescribe these controlled substances.

There are several methods of drug testing. We have chosen what we feel are the least invasive methods—urine testing and saliva testing. Because the system is *random*, you may *never* be asked to undergo a drug screen, *or* you may be asked to do so one or two times in a one-year period. You may also be asked to provide a drug screen at *any time*, or to provide *another type of drug screen* (e.g., a hair follicle test) if Dr. Fairweather deems it in the best interest of your health.

To avoid delays, please arrive for *each visit* with a sufficiently full bladder so that you can provide a small urine sample.

Costs for all tests are your financial responsibility. The cost of a urine or saliva drug screen is $70 and is nonrefundable. Specialty tests, if deemed necessary by Dr. Fairweather, may cost more, depending on the test(s) ordered.

We understand that change can often be stressful, but we believe that the benefits afforded to you by this testing are a positive step towards more comprehensive medical care.

Unless otherwise indicated, your signature below confirms that you understand and agree to each paragraph above.

_____	_____	_____
Patient Printed Name	Signature	Date

Credit Card Authorization

c

Please be aware that all patients at Fairweather Medical Group are required to have a credit card to be kept on file, and we are not able to make exceptions to this policy Credit card data will be kept securely. We appreciate your cooperation.*

Patient Name: _____ I, _____,
Printed Name of Card Holder

1) Certify and assure that I am an authorized user of the credit card listed below, and
2) Authorize Fairweather Medical Group (FMG) to make charges on the card listed below, without any further prior notification(s) to me, for any and all costs and fees associated with the care of the patient listed above. These costs and fees are outlined in the new patient packet*****, signed by the patient on _____.
Date

These charges include but are not limited to fees for:

No-shows and late-rescheduled appointments, prescription refills between visits, drug screens, lab draw fees, completion of paperwork if requested by the patient, copies of medical records, completion of paperwork, and all other costs and fees associated with the treatment, testing, collaboration with other treatment providers, interpretation of labs, tests, or other data pertinent to the patient's medical care, or any other services deemed necessary for the best care and treatment of _____ by Dr. Fairweather or her staff.
Printed Name of Patient

3) Should I have questions or concerns about charges made by FMG to the card listed below, I will first attempt to clarify any such issues by speaking directly with (or forwarding a letter to) Shawn Fairweather, Director of Compliance at Fairweather Medical Group, at 817-283-4300, or in writing to the address listed below. If am still unable, after doing so, to get satisfactory resolution to an issue, I may then contact the issuer of the credit card listed below.

Please bear in mind that your satisfaction is our top priority, and we will always *work with you to to resolve any payment issues or concerns that may arise during treatment*

This authorization will remain in effect until either:

1) The card listed below expires, or
2) A replacement card is put on file, or
3) The cardholder notifies Fairweather Medical Group in writing* that they no longer wish to have this card on file for the purposes listed above, which ever occurs first.

*This document may be hand-delivered or mailed to: FMG—Compliance Department
4016 Gateway Dr. #120 Colleyville, TX 76034

Name of Credit Card Owner: _____

Credit Card Number: _____ _____ _____ _____

Expiration Date: _____ / _____ Billing Address for Card: _____

_____ _____
Date Signature of Card Holder

*****You may obtain a copy of the above-mentioned new patient packet by going to our website at doctorLisaFairweather.com and clicking on "Download New Patient Paperwork."

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.