C. Scott Moreland, D.O., PLLC
Child, Adolescent, & Adult Psychiatrist
12946 Dairy Ashford Road, Suite 260
Sugar Land, TX 77478
Phone 281-242-2595 / Fax 281-242-2909
www.sugarbendcenter.com

Consent for Evaluation/Treatment

Patient's Name: _____ Date of Birth: _____

I _____, hereby give full consent to receive services of C. Scott Moreland, D.O., PLLC until I notify him or he determines services are no longer appropriate or will no longer be provided. I certify that I have the legal authority to authorize and consent to this treatment. For this document, treatment refers to therapy, medication management, or both. If medication is an option, then I will be referred to a separate medication consent.

CONFIDENTIALITY
I understand that any information I provide to C. Scott Moreland, D.O., PLLC is confidential and generally will not be released to others without my written consent. However, I understand that professional ethical obligations, state and/or federal law might require C. Scott Moreland, D.O., PLLC to disclose confidential information without my consent in certain circumstances. I understand C. Scott Moreland, D.O., PLLC may be required to disclose confidential information, without my consent, in one or more of the following situations:

In the event that the therapy session reveals any information concerning the abuse of a child, elder or disabled person, C. Scott Moreland, D.O., PLLC. is mandated by law to make a report to the proper authorities. By signing this document, I acknowledge my awareness of this fact.

If the course of treatment reveals any intent I may have to harm either myself or others, I acknowledge C. Scott Moreland, D.O., PLLC's legal and moral duty to prevent this harm about. I specifically give my irrevocable permission to warn those parties he feels may be harmed. If I reveals an intent to harm myself, C. Scott Moreland, D.O., PLLC has my permission, also irrevocable, to prevent me from accomplishing that intent.

If I have been referred to this practice by a managed care or insurance company, or I plan to request C. Scott Moreland, D.O., PLLC to file for reimbursement with a managed care or insurance company, I am aware of this arrangement. As a requirement of the managed care or insurance company, I understand C. Scott Moreland, D.O., PLLC may be required to provide them with a complete copy of the records generated in my treatment. Once these records are in the possession of the managed care or insurance company, C. Scott Moreland, D.O., PLLC cannot guaranty their continued confidentiality.

Additionally, if a law suit is filed by me against C. Scott Moreland, D.O., PLLC for breach of duty; or if a court order, legal proceeding, statute, or regulation requires disclosure of records, I understand legal obligations may require the release of my treatment records.

RECORDS
I understand it is stated law that mental health professionals maintain a record of the treatment given to me. This record will contain the information that will allow Dr. Moreland to chart the course of treatment. He will use it only for that purpose. It is his intent that no one will ever see what is contained in the file. I understand I may get a copy of the file only by providing him with a signed release of information request. Dr. Moreland may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record. I agree I will pay in advance for either the copying cost of the actual record or the time required for the preparation of the treatment summary. This includes providing copies or reports to any court or legal representative or designate. In the event of your death, these requirements will be binding on any heirs, successors or executor(s).

If the treatment sessions contain more than one patient, I agree that no one person may get the complete treatment file. I agree Dr. Moreland, may synopsize the course of each individual's treatment as opposed to providing a copy of what notes may have been made during any treatment session. I also understand that if Dr. Moreland believes certain information in the chart will be detrimental to my health that information will be blacked out.

PAYMENT:
I understand payment is due at the time of service. Payment schedule will be made known to me before my initial session.

MISSED/RESCHEDULED APPOINTMENTS:
If I need to cancel or reschedule an appointment with Dr. Moreland, I agree to contact his office at least 24 hours in advance. This will allow those who are waiting for an appointment the opportunity to be scheduled in my place. **If I do not provide this notice, I understand I need to pay a $75.00 'no cancellation' fee for each occurrence**. This fee is not covered by insurance and needs to be paid before or at the next appointment. A pattern of missed appointments may result in our referring you to a provider who can better accommodate your schedule.

TERMINATION OF TREATMENT
I understand the length of time required for treatment will be determined by my personal situation. I understand Dr. Moreland will do his best to fulfill my therapeutic needs and to provide his best professional care. For my part, I agree to participate in the process to the best of my ability. It is intended that when my needs are met, to the extent that they can be, we will terminate our relationship.

I understand I may terminate treatment at any time. This may be accomplished in any one of several ways. These include, but are not limited to, putting it in writing, informing me verbally, failing to maintain my appointment schedule without proper notification, or failure to follow treatment recommendations. I understand Dr. Moreland will respect my wishes to terminate treatment. I also understand the method I choose to accomplish termination will impact any decision to resume a therapeutic relationship with him.

My signature on this consent form verifies that I have had the opportunity to ask questions regarding procedures, policies, and therapeutic techniques, that my questions were answered to my satisfaction by Dr. Moreland, and that I voluntarily give my consent for treatment. I understand that I have the right to withdraw my consent for treatment at any time.

_____ _____
Signature Date

_____
Printed Name

ADULT HISTORY QUESTIONNAIRE

Please take a few moments to complete this questionnaire. Feel free to write on the back of the page.

Name: _____ Date of Birth: _____ Date:_____

Address: _____

City: _____ Zip: _____

Home Phone: _____Leave a message on this line? Yes No

Work Phone: _____ Leave a message on this line? Yes No

Cell Phone: _____ Leave a message on this line? Yes No

Email address: _____

How did you find out about me? _____

REASON FOR SEEKING AN EVALUATION/SERVICES:

What problems are you struggling with that have brought you here today? _____

_____

_____

_____

_____

How long have the above issues been of concern?_____

_____

What Interventions/treatments have you tried? _____

_____

What are you hoping to achieve from today's evaluation? _____

_____

MENTAL HEALTH HISTORY

Have you ever seen a therapist, psychiatrist or counselor before? If so, what were the circumstances?

_____

_____

_____

Did or do you find therapy helpful?

_____

Are you currently taken any medications to help with any mental health problems? If so, please list the name, dose, how often, and reason for each medication. _____

_____

Is the medication helpful?_____
Any side effects? _____

Please list all other medication(s) taken in the past for mental or behavioral problems. (State the medication, dose, how often, reason, was it helpful and why was it stopped).

_____
_____
_____
_____

Have you ever tried to harm or kill yourself? No Yes, please explain the circumstances.

_____
_____
_____

Have you ever been in a psychiatric hospital before? No Yes, please explain:

_____
_____

EDUCATION/EMPLOYMENT BACKGROUND

Highest level of education completed: _____

Was school difficult for you? No Yes _____
_____
_____

Were or are you an average, poor, exceptional student?

_____

What is your current employment status? i.e. Working part time? Working full time? Have you changed jobs recently? Are you a student?

_____
_____

If employed, are you content with your current employment?

_____

FAMILY

Please list family members who live in the home with you, their ages and relationship to you

_____ _____
_____ _____
_____ _____

Are there any children who live elsewhere? Please list their names, ages, and reason for moving out._____
_____

_____

_____

Has there been a divorce in the family? If so, when? If there are children, what are the custody arrangements? _____

_____

Are there any other family members who are very actively involved in your family life? If so, who?

_____

STRESSORS

Have you experienced any stressful events in the last year? Please check the following.

- ☐ Death in the family
- ☐ Death of a close friend
- ☐ Serious illness or injury, your own
- ☐ Serious illness or injury, a loved one
- ☐ Family fighting
- ☐ Marital problems
- ☐ Divorce or separation
- ☐ Marital reconciliation
- ☐ Problems with child rearing
- ☐ Move to a new home
- ☐ Son or daughter leaves home
- ☐ Conflict with in-laws
- ☐ Change in job - new position, new company, laid off, retired, quit
- ☐ Change in financial status, either more or less money
- ☐ Legal Problems
- ☐ Change in daily responsibilities
- ☐ Change in social network
- ☐ New marriage in the family
- ☐ Outstanding personal achievements
- ☐ Other: _____

MEDICAL HISTORY

Do you have any of the following medical problems?

Current	Past		Current	Past	
☐	☐	Heart Problems	☐	☐	Head Injury
☐	☐	Digestive Problems	☐	☐	Surgeries
☐	☐	Hypothyroidism	☐	☐	Tics
☐	☐	Hyperthyroidism	☐	☐	High Blood Pressure
☐	☐	Diabetes, Type I	☐	☐	Reproductive Problems
☐	☐	Diabetes, Type II	☐	☐	PMS symptoms
☐	☐	Overweight	☐	☐	Muscle tension
☐	☐	Underweight	☐	☐	Headaches
☐	☐	Back or neck pain	☐	☐	Cancer

If you checked any of the boxes on the previous page, please describe the problem.

_____
_____
_____
_____

Are you currently taking any medications? If so, please list. _____
_____
_____
_____

Are there any other medical problems not listed above that you experience? _____
_____

Please list the name, address and phone number of your PCP._____
_____
_____

When was your last physical exam?_____

RECREATION

How do you spend your "free time"?_____
_____

Please check the following activities that you engaged in the last month.

- ☐ Exercise, how frequently? _____
- ☐ Out with friends, how frequently? _____
- ☐ Out with spouse, how frequently? _____
- ☐ Relax, how frequently? _____
- ☐ Took time to yourself, how frequently? _____
- ☐ Enjoyed something?_____

What do you hope to gain out of this evaluation &/or treatment?

_____

_____

_____

_____

Have you or any of your family members struggled with any of the following problems?

	Myself, current	Myself, past	Parent	Sibling	Child	Spouse
Depression, sadness						
Anxiety / Excessive Worries						
Panic Attacks						
Obsessions and/or Compulsions						
Suicidal thoughts						
Attempted Suicide						
Learning Disabilities						
Attention Deficit/Hyperactivity						
Problems with Anger						
Problems with Assertiveness						
Oppositional/Defiant						
Schizophrenia or Psychosis						
PTSD						
Heavy Alcohol Use						
Drug Use/Abuse						
Eating Disorder						
Abused in any way						
Other:						

Is there anything else you would like to make sure I know? _____

_____

_____

_____

_____

When completed with this evaluation, you may fax, mail it, or drop at our office ***before your appointment:***

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Please continue to next page to complete form

NOTICE OF PRIVACY PRACTICES

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information

This notice will explain how we handle your medical/mental health information. Applicable federal and state laws require us to maintain the privacy of clients' personal and health information. In this Notice, your personal or protected health information is referred to as "health information" or "PHI" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income or other financial information. Because state and federal laws, combined with our professional ethics, are very complicated, some parts of this notice are very detailed and may seem difficult to understand. Please know C. Scott Moreland, D.O., PLLC is committed to protecting the privacy of your health and personal information and is available to answer any questions you may have.

How We Protect Your Health Information

C. Scott Moreland, D.O., PLLC. protects your health information by treating all of your health information that he collects as confidential (for exceptions to confidentiality see Consent for Treatment), by training all staff in federal and state confidentiality policies and practices per HIPAA, by restricting access to your health information only to those office staff that needs to know your health information in order to provide her services to you, and by maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

C. Scott Moreland, D.O., PLLC. may use or disclose your protected health information for treatment, payment, and health care operations purposes if you have given consent to receive evaluation or treatment services.

Clarification of terms:
PHI- information in your health record that could identify you.
Treatment, Payment, and Health Care Operations
Treatment- when office provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when our office consults with another health care provider, such as your family physician.
Payment- when you provide reimbursement for the services you receive in the office. An example of payment would be when our office discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations – are activities that relate to the performance and operation of our office. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, case management and care coordination, and conducting training and educational programs or accreditation activities.
Use – Activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
Disclosure – Activities outside of the office, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

C. Scott Moreland, D.O., PLLC and any administrators of his may use or disclose PHI for purposes outside Treatment, Payment, or Health Care Operations when your authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the office is asked for information for purposes outside of Treatment, Payment, or Health Care Operations, we will obtain an authorization from you before releasing this information.
Specific authorization is also obtained before releasing your psychotherapy notes. Psychotherapy notes are notes made about treatment and are given a greater degree of protection than PHI.
You may revoke all such authorizations at any time, provided each revocation is in writing. After that time, we will not use or disclose your information for the purposes originally agreed upon. However, we cannot take back any information already disclosed with your permission or that we had used in our office.

Uses and Disclosures Not Requiring Consent or Authorization

The law lets C. Scott Moreland, D.O., PLLC use or disclose PHI without your consent or authorization in some cases. Here are some examples of when this might occur:

When Required by Law - Suspected child abuse must be reported. Also, if you are involved in a lawsuit or legal proceeding and the provider receives a subpoena, discovery request, or other lawful process, some of your PHI may have to be released. This will occur only after trying to tell you about the request, consulting your lawyer, or trying to get a court order to protect the information being requested. Finally, some information has to be disclosed to governmental agencies, which check on providers to see that privacy laws are being obeyed.

For Law Enforcement Purposes – Information may be released if your provider is asked to do so by a law enforcement official to investigate a crime or criminal.

For Public Health Activities – Some of your PHI might be disclosed to agencies which investigate diseases or injuries.

Relating to Decedents – PHI might be disclosed to coroners, medical examiners, or funeral directors, and to organizations relating to organ, eye, or tissue donations or transplants.

For Specific Government Functions – PHI of military personnel and veterans may be disclosed to government benefit programs relating to eligibility and enrollment. PHI may also be disclosed to Workers Compensation and Disability Programs, to correctional facilities if you are an inmate, and for national security reasons.

To Prevent a Serious Threat to Health or Safety – If your provider believes that there is a serious threat to your health or safety or that of another person or the public, the provider can disclose some of your PHI. This disclosure will only be provided to persons who can prevent the danger.

Patient Rights and Provider's Duties

Patient Rights:

Rights to Request Restrictions – You have the right to request that your provider limits what is told to people involved in your care or the payment of your care, such as family members and friends. C. Scott Moreland, D.O., PLLC may not be able to accept your request; however, if accepted she will uphold it except in case of emergency or if it is against the law.

Right to Receive Confidential Communications by Alternative Means/Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at the office. On your request, communications will be sent to an alternate address.)

Right to Inspect and Copy – You have the right to inspect and/or obtain a copy of your records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request in writing an amendment of your health information for as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

Electronic vs. Paper – If you received this notice electronically (e.g., accessing a website) you have the right to obtain a paper copy of the notice from the office upon request.

Duties of C. Scott Moreland, D.O., PLLC

Provider is required by law to maintain the privacy of PHI and to provide you with this notice of legal duties and privacy practices.

C. Scott Moreland, D.O., PLLC reserves the right to change the privacy policies and practices and terms of this Notice at any time, as permitted by applicable law. He reserves the right to make the changes in privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect.

Questions and Complaints

For questions regarding this Notice of our Privacy Practices, or if you are concerned that your privacy rights may have been violated, please contact C. Scott Moreland, D.O., PLLC. You may also make a written complaint to the US Department of Health and Human Services, whose address can be provided upon request. If you choose to make a complaint with the US Department of Health and Human Services, or with me, I will not retaliate in any way.

C. Scott Moreland, D.O., PLLC
12946 Dairy Ashford, Suite 260
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281-242-2595

CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

In my notice of Privacy Practices, I provided you with information about I can use or disclose your personal and health information. As described in my Notice of Privacy Practices, I request your consent for use or disclosure of mental health and medical information to carry out treatment, payment, or health care operations. You have a right to review my Notice of Privacy Practices before signing this Consent form.

By signing this Consent form, you: (1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment, or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing any time, except where we have already used or disclosed your health information in reliance upon this Consent.

_____ _____

Signature of Patient or Legal Representative Date

_____

Patient's Name (Printed)