Neysa L. Johnson, M.D., P.L.L.C.
305 Miron Drive
Southlake, TX 76092

INSTRUCTIONS:
At this time, the office is unable to support these forms being filled out online. Please print them, fill them out by hand, and bring them to your first appointment. These forms will help you understand the way the office operates, usual procedures, and help provide me with a thorough history. Thank you for taking the time to fill them out.

1. POLICIES & PROCEDURES FOR PATIENTS and CONSENT FOR TREATMENT
Please read and keep for your records.

2. NOTICE OF PRIVACY PRACTICES
Please read and keep for your records.

3. PATIENT REGISTRATION AND ACKNOWLEDGMENT OF FORMS
Please fill out completely and bring with you to your first appointment. Your signature represents receipt of the first two forms listed above and will be kept in your record.

4. CREDIT CARD POLICY AND AUTHORIZATION FORM
Please fill out completely and bring with you to your first appointment.

5. PATIENT MEDICAL AND PSYCHIATRIC HISTORY
Please fill out completely and bring with you to your first appointment. Although this information will also be reviewed with you at your appointment, filling out the forms will help you provide a thorough history, including past psychiatric medications and response.

6. AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION
Please fill out as much as you are able, especially if you would like me to send a letter to your primary care physician and/or therapist (please include their mailing address and fax number). Bring this with you to your first appointment. If you do not think I will need or want to speak with anyone regarding your care, you do not need to fill out this form. This form will also be available at my office.

I look forward to meeting you. Please call me if you have any questions or concerns prior to our appointment.

Neysa L. Johnson, M.D., P.L.L.C.
POLICIES & PROCEDURES FOR PATIENTS and CONSENT FOR TREATMENT

Please read the following thoroughly and keep for your records. You will sign the patient registration form stating you have received and agree with the terms.

General:
Welcome to the office of Dr. Neysa Johnson. I am a board-certified psychiatrist who provides evaluation, consultation, diagnosis, and treatment to adults suffering from psychiatric, psychological, or mental disorders.

When you call the office requesting an appointment, I will briefly discuss your problems with you and determine if an evaluation would be helpful. If I feel that I will be able to assist you, an initial consultation will be scheduled. This initial consultation will be 50-60 minutes long. Generally, that is adequate time to make a "working" diagnosis and determine an initial treatment plan. Occasionally an additional evaluation session is needed. At the end of the initial evaluation, we will discuss a proposed treatment plan. Please be aware that the initial visit is for consultation only and does not necessarily imply a long-term treatment relationship. I feel it is important for us to meet each other to see if there is a good connection and that both parties mutually agree to continued care.

When describing the treatment plan, I will give you an idea of the treatment recommended, such as medications and/or psychotherapy. Every person responds differently to treatment. Follow up visits will be necessary to evaluate your response to treatment as well as to continue to monitor your symptoms. If I determine that I am unable to assist you, I will attempt to refer you to someone who can. However, after the first consultation, either party can decide that there will not be a future treatment relationship.

Scheduling:
My schedule is similar to a therapist's in that I will start and end a session at the time scheduled. If your appointment is at 2:00, please be there by 2:00. If you are late, the visit will not be extended, as this would be discourteous to the next client. If you have missed more than half of your appointment time for a follow up or more than 20 minutes for a first appointment, the appointment will need to be rescheduled and it will be considered a "no show" appointment. Occasionally an emergency with another patient could cause me to be delayed, but this will be rare. An attempt to contact you will be made if I am aware there may be a delay in your appointment.

No Show Visits:
If you are unable to come to your appointment, please give at least 24 hours notice. If you provide less than 24 hours notice (or no notice), you will still be charged the usual fee on the day of your missed appointment via your credit card on file. I do understand that emergencies happen, and we can discuss extenuating circumstances, but the decision to not charge the full fee will be at my discretion.

Reminder Texts:
Reminder texts for appointments are generally automatically placed as a courtesy. These calls are not mandatory and **not receiving a reminder does not mean you no longer have an appointment.**

Inclement Weather:
If there is a winter storm or other extreme weather, either party can cancel the appointment with less than 24 hours notice without charge for a no show visit.

Prescription Refill Requests:
You should be aware of the amount of medication you have left and when you will need a refill. I will generally prescribe enough medication to last until your next appointment. If you miss an appointment, it is your responsibility to request a refill so that you do not run out of medication. I may refuse to give a refill if I have not seen you recently and feel that an office appointment is clinically indicated. To request a refill, please contact your pharmacy and they will fax me. Please provide 48-72 hours to process the refill. Refills are **not** processed over the weekend.

Texting:
My phone does not accept texts; please do not text me. (Note that the reminder texts you receive are made automatically from my medical record provider, and they are located on the East Coast).

After Hours Messages:
The office phone line is forwarded to my cell phone after hours and on weekends and holidays. If at all possible, please only call with urgent messages during those times. You will still have to leave a voicemail, and I will check the voicemail and return your call as soon as I am able.

Emergencies:
If you are having an emergency such as a serious side effect to a medication or concerning symptoms, please call me. Please call me at any time if you are having thoughts of hurting yourself or other dangerous or scary thoughts. I will do my best to assist you over the phone. We will work together to help ensure your safety. Sometimes I may request that you go to an Emergency Room or call 911. If you are calling me urgently, but I have not returned your call in a manner you consider timely, please go to the nearest Emergency Room or call 911 in order to ensure your safety and health.

Email Messages:
Email is extremely convenient and is a way to avoid frustrating "phone tag." However, you should be aware that email is inherently **NOT** secure. My email address and server are not encrypted, and other personal email accounts such as with Yahoo or Gmail are also not encrypted. If you wish to put confidential personal or health information in the email, please realize that there is potential for the message to be intercepted and possibly even published. The office is not responsible for any security breach.

Payment:
I do not accept insurance payments directly. Payment is expected at the time of service unless other arrangements have been made. The office accepts cash (correct change only), checks, or credit cards. An invoice that you can submit to your insurance will be provided. It is your responsibility to contact your insurance to establish what you will be reimbursed.

A credit card number is kept on file in case of a no show visit or balances unpaid after 30 days. After 90 days, unpaid balances will be submitted to a collections agency, and you will be responsible for the original balance as well as any collections' or attorney's fees.

Other Providers:
Since many psychiatric symptoms can be caused or exacerbated by medical illness, I strongly suggest you have a primary care physician so that medical causes of symptoms can be ruled out. I will be happy to send a letter to your primary physician describing the evaluation, diagnosis, and treatment recommendations at your request and with your authorization.

Psychotherapy:
I usually recommend psychotherapy as either a primary treatment or as an additional treatment along with medications. With your authorization, I will be happy to consult with your therapist if you already have one, or to help you find a therapist. I am **not** currently accepting new psychotherapy patients.

Problems & Communication:
If you are experiencing any problems, either as a result of a treatment side effect or due to an issue in our therapeutic relationship, please do not hesitate to discuss it with me. Your well-being is my highest priority.

Consent for Treatment:
By your signature on the Patient Registration form, you acknowledge that you are presenting yourself to Neysa L. Johnson, M.D., P.L.L.C. ("Dr. Johnson," "the office," "I") for evaluation, diagnosis, and/or treatment of a medical or psychiatric condition. You give consent and authorize Dr. Johnson or her designees to order and/or perform all exams, tests, procedures, and any other care deemed necessary or advisable for the evaluation, diagnosis, and treatment of this medical condition. This consent is valid for each visit made to the office, unless and until revoked in writing.

By your signature, you acknowledge that you have read and understand the information obtained in this consent and the policies and procedures. You accept the terms of this consent and the policies and procedures of the office.

Neysa L. Johnson, M.D., P.L.L.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Each time you visit the office, a record of your visit is made. This record contains your symptoms, diagnosis, treatment and plan for future care or treatment. It serves as the basis for planning your care and treatment. However, it also can act as a legal document describing the care you received and as a means by which you or a third-party payer can verify that the services billed were actually provided. It may also be a means of communicating with other health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand, who, what, when, where and why others may access your health information, and make more informed decisions when authorizing release to others.

YOUR HEALTH INFORMATION RIGHTS:
Although your record is the physical property of Dr. Johnson, the information belongs to you. You have the right to:
- Request restriction on certain uses of your information
- Obtain a paper copy of the Notice of Privacy Practices
- Amend your health record according to legal protocol
- Request communications of your health information by alternative means
- Revoke your authorization to use your health information except to the extent that action has already been taken or is required by law

MY RESPONSIBILITY:
I am required to:
- Maintain the privacy of your health information
- Provide you with a notice as to my legal duties and privacy practices with respect to the information I collect about you
- Abide by the terms of this notice
- Accommodate reasonable requests you may have to communicate health information by alternative means
- I will not use or disclose your health information without your authorization, except as described in this notice.

INSPECTION OR COPIES OF HEALTH INFORMATION:
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons: the information is psychotherapy notes, the information reveals the identity of a person who provided information under a promise of confidentiality, the information is subject to the Clinical Laboratory Improvements Amendments of 1988, or the information has been compiled in anticipation of litigation. Additionally, if the information in the record could cause mental harm to you, a summary will be provided instead.

AMENDMENT OF MEDICAL INFORMATION:
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons: the information wasn"t created by this practice or the physicians in this practice, the information is not part of the designated record set, the information is not available for inspection because of an appropriate denial, or the information is accurate and complete. Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an

amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

EMAIL:
Email is inherently insecure. However, it is also extremely convenient. After care is established with Dr. Johnson, email may be used if both parties are agreeable. **By you engaging in an email conversation with Dr. Johnson or her office, you are also acknowledging that you are aware of the possibility of inadvertent release of this information and that information sent over email is easily readable by others and can be subject to publication, although attempts are made to keep the information secure**. In view of this, please **do not use a work email as your main email address**. Generally, messages sent through a work email are property of your employer and could be easily intercepted and read. Email will be archived in your medical chart.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS
I will use your health information to provide treatment. With your permission I will share this information with your other doctors or family members. If a third party payer is paying for the bill, then they will get information that identifies you, as well as your diagnosis and the type of treatment provided. In addition, I may be required to disclose health information for law enforcement purposes, or in response to a valid subpoena, or in relationship to a workers' compensation claim. I will make every effort to inform you if such a request is made of me.

Your safety is Dr. Johnson's highest priority. Other medical providers (for example, a therapist), family members, friends, neighbors, your place of employment, or police may be notified if there is significant concern for your safety or the safety of others. If feasible, Dr. Johnson will attempt to get your permission, but this can be done without your permission or even if you protest if your safety is at risk. The fewest number of people will be notified in order to ensure your safety (i.e., your place of employment or neighbors would be notified only if their notification would be of immediate benefit to you or someone else).

OTHER DISCLOSURES REQUIRED BY LAW:
Because Texas law requires physicians to report **child abuse or neglect**, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

COMPLAINTS, QUESTIONS AND CONTACT FOR REQUEST:
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.
If you have any questions or want to make a request pursuant to the rights described above, please contact:

Neysa L. Johnson, M.D.
305 Miron Dr.
Southlake, Texas 76092 817.479.9363 This notice is effective June 1, 2013

Neysa L. Johnson, M.D., P.L.L.C.
PATIENT REGISTRATION AND ACKNOWLEDGEMENT OF FORMS

Demographic Information:
Full Legal Name: _____ Preferred Name: _____

Date of Birth: _____ SS#: _____

Home Street Address:
_____

Home City/Sate/Zip:
_____

Occupation: _____ Employer: _____
Marital Status: _____
Spouse/Partner‟s Full Name:
_____

Phone Numbers:
Cell: _____ ___ Preferred phone for reminders?

Home: _____ ___ Preferred phone for reminders?

Work: _____ ___ Preferred phone (not advised)?

Email: (see Policies/Consent & Privacy Forms)
Personal: _____ ___ Preferred email for reminders/messages?

Work: _____ ___ Preferred email (not advised)?

Emergency Contact Information: (see Policies/Consent & Privacy Forms)
#1 Contact (may live with you):
Name: _____ Relationship to you: _____
Home Address: _____
Cell Phone: _____ Home Phone: _____

#2 Contact (does not live with you):
Name: _____ Relationship to you: _____
Home Address: _____
Cell Phone: _____ Home Phone: _____

Referral Source:
Who referred you to Dr. Johnson?
_____
This person's relationship to you?
_____
If you were not referred by someone, how did you find out about Dr. Johnson?
_____

Your Other Medical and Mental Health Providers:
Primary Care Physician:
Name: _____ Phone Number: _____
Address: _____
Fax: _____
Last Time You Saw This Provider and Reason: _____

Therapist:
Name: _____ Phone Number: _____
Address: _____
Fax: _____
Last Time You Saw This Provider and Reason: _____

Obstetrician/Gynecologist (if applicable):
Name: _____ Phone Number: _____
Address: _____
Fax: _____
Last Time You Saw This Provider and Reason: _____

Other Providers/Specialists (please list name, specialty, and reason for seeing):
_____

_____

Pharmacy: _____ **Pharmacy Phone:**_____

Pharmacy Address: _____

ACKNOWLEDGEMENT OF FORMS/POLICIES/STATEMENTS:
___ I certify that I have reviewed the office's Policies & Procedures For Patients and Consent for Treatment, and I agree to its terms, including the **payment policy, email policy, and no show policy.**

___ I certify that I have reviewed the office's Notices of Privacy Policies, and I agree to its terms.

Signature: _____ Date: _____

Printed Name: _____

Neysa L. Johnson, M.D., P.L.L.C.
CREDIT CARD POLICY AND AUTHORIZATION FORM

It is a policy of the office to keep a credit card on file in case of a “no show" visit (late or no cancellation) or balances unpaid after 30 days. Your credit card information will be protected along with the rest of your information. You may also choose to have this credit card charged with your regular session fees. Please let the office know if you wish to do this.

Name on Credit Card: _____

Billing Address & Zip Code: _____

_____

Credit Card Type: _____ Number: _____

Expiration Date: ___/___

I have read and agree to the office’s policy of keeping a credit card on file to be used for unpaid balances and no show visits. Regular fees will be charged with my verbal permission. No show visits will be charged the day of the missed appointment.

Authorized Signature: _____ Date:_____

Neysa L. Johnson, M.D., P.L.L.C.
PATIENT MEDICAL AND PSYCHIATRIC HISTORY

Name: _____ Date Form Filled Out: _____

MEDICAL HISTORY:
Medication or Food Allergies / Types of Reaction: _____
_____
Current Medical Problems:_____
_____
Any surgeries / Year of Surgery: _____
_____
All Current Prescription Medications (include name, dosage, and frequency):
_____
_____
_____
_____
_____

All Current Over-The-Counter Medication (include pain relievers, vitamins, herbs, even if only occasional use): _____
_____
_____

REVIEW OF SYMPTOMS—are you currently having any of the following medical problems (please circle)?

Fatigue	Insomnia	Weight Loss	Weight Gain
Vision Problems	Hearing Problems	Trouble Swallowing	Seizures
Headaches	Dizziness	Muscle Pain	Joint Pain
Cold Intolerance	Shortness of Breath	Chest Pain	Nausea
Vomiting	Diarrhea	Constipation	Rectal Bleeding
Painful Urination	Vaginal Discharge	Abnormal Periods	Penile Discharge
Sexual Problems	Easy Bruising	Fever	Chills

If you circled any of the above, please describe: _____
_____
_____

Family History of Medical Problems: _____
_____
_____

Family History of Psychiatric Problems (include psychiatric illness, suicides, and substance abuse):_____
_____
_____
Your tobacco use (describe): _____
Your alcohol use (describe): _____
Your drug use (describe): _____

PSYCHIATRIC HISTORY (please use additional pages if needed):

How old were you and what were the circumstances when your first sought psychological or psychiatric care? _____
_____
_____

Please list prior psychiatric diagnoses you've been given, including substance abuse problems and personality disorders (if any) and whether you think the diagnosis is/was accurate:_____
_____
_____

Have you ever had a psychiatric hospitalization? If yes, describe reason, location, and date for each hospitalization: _____
_____
_____

Have you ever attempted suicide? If yes, please describe method and date of each attempt:
_____
_____
_____

If applicable, discuss the most recent changes in your psychiatric medications and the results of these changes _____
_____
_____
_____

Please list any/all psychiatric medications you remember being on in the past:

Medication/Dosage	Helpful?	Side Effects?	Length of Time on It

If applicable, who is currently prescribing/managing your psychiatric medications?
_____

Any additional information about your psychiatric history that I should know?
_____
_____

<u>For Females Only</u>—Reproductive History:

Current Information:
Last Menstrual Period: _____

Are you currently Breastfeeding? _____

Type of Birth Control: _____ Planning a Pregnancy? _____

Are you currently pregnant? (circle) Yes No
If no, please skip to next section.
Estimated Due Date: _____ How many weeks are you? _____
Are you planning to breastfeed? _____

Past History:
Age Periods Began: _____
Age periods ended (if applicable): _____
Have periods ever stopped (other than due to pregnancy or menopause? _____
If yes, when/why (if known): _____

Any treatment for fertility issues (describe)? _____
_____

Has PMS/PMDD ever been a problem (describe)? _____
_____

Pregnancy History:
#Total Pregnancies _____ # Miscarriages _____ # Abortions _____

Date	Delivered/ Stillbirth/ Miscarriage/ Abortion	Weeks at Delivery	Baby's Name	Baby's Gender	Baby's Weight	Pregnancy Complications?	Fertility Treatments Needed?	Any psych issues/meds during pregnancy?

Neysa L. Johnson, M.D., P.L.L.C.

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Neysa L. Johnson, M.D., P.L.L.C., ("practice") to obtain, use, and disclose the protected health information described below for the following purposes (check applicable uses):

___ Coordination of medical care, including obtaining or providing history, current or past treatment, including psychological and psychiatric records and treatment

___ Providing information to workplace or insurance for disability, leave of absence, or to assist in payment

___ Obtaining or providing collateral information to aid in history and treatment planning and facilitate care

___ Providing clinical information to state or regulatory agencies (Department of Health & Human Services/CPS, professional boards, etc.)

___ Other:

_____

This use or disclosure will be made by the office staff of this practice.

The health information to be given or received is specifically described as follows:

__ Initial evaluation
__ Progress Notes
__ Medication records
__ Lab results (including HIV)
__ Treatment Plans
__ Billing records
__ Substance use/treatment information
__ Psychological testing
__ Collateral information/additional history
__ All of the above

The person, class of persons, or company to whom the information will be disclosed or who will use the information is:

_____
_____
_____

The practice is hereby authorized to make the disclosure to these classes of persons and the aforementioned classes of persons are hereby authorized to use or disclose the information. This authorization shall be in force and effective until **one year following the last appointment with this office, unless otherwise noted.** I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Neysa L. Johnson, M.D., P.L.L.C at the following address: 305 Miron Drive; Southlake, Texas 76092. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____

Signature of Patient or Representative Date

_____

Printed Name of Patient or Representative