



Fig Tree Behavioral Wellness
Dr. Velma Vega-Hughes, DNP, APRN, PMHNP-BC

Board Certified Psychiatric Mental Health Nurse Practitioner
 Office: 956-230-8880 Fax: 956-474-2753

Email: info@figtree.care
 www.figtreebehavioral.com

NEW PATIENT REGISTRATION FORM

Today's Date:		How did you hear about our service?	
Person Filling Out Form:		Relationship to Patient:	
Patient's Name:			
Patient's DOB:		Patient's Age:	Phone:
Address/City/State/Zip:		Email:	
Current medical insurance:			
Member Id:		Group#:	Customer Service#:
Primary Care Provider/ Family Doctor:			
Chief complaint/Reason for Appointment:			
Diagnosed with a mental health condition: <input type="checkbox"/> No <input type="checkbox"/> Yes When?			
List all current medications with dosage:			
Currently seeing a Therapist: <input type="checkbox"/> No <input type="checkbox"/> Yes Therapist: _____ How long?			
History of psychiatric hospitalization or testing: <input type="checkbox"/> No <input type="checkbox"/> Yes When & What for?			
Eating Disorder: <input type="checkbox"/> No <input type="checkbox"/> Yes Current/how long ago?			
Substance abuse (illicit and/or prescribed drugs/alcohol/tobacco, etc) <input type="checkbox"/> No <input type="checkbox"/> Yes Current/how long ago?			
Suicidal ideations: <input type="checkbox"/> No <input type="checkbox"/> Yes Current/how long ago?			
Thoughts of harming others <input type="checkbox"/> No <input type="checkbox"/> Yes Current/how long ago?			



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CREDIT CARD AUTHORIZATION

I, _____, am authorizing Fig Tree Behavioral Wellness to (Print Patient's Name or Guarantor's Name)

Charge my credit card if I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment in advance.

Please remember that all appointments need to be cancelled at least 24 business hours in advance in order to avoid and fees. All no shows/same day cancellations will be charged \$100. **THERE ARE NO REFUNDS ONCE YOUR CREDIT CARD ON FILE HAS BEEN CHARGED FOR THESE FEES.**

Please note reminder calls/texts/e-mails is a courtesy. You are responsible for your appointment whether your reminder was received or not.

I further authorize Fig Tree Behavioral Wellness to disclose information about my attendance /cancellation to my credit card company if I dispute a charge.

Card Type (**circle one**): Visa MasterCard Discover American Express

Card #: _____ CVV: _____ Exp Date: _____

Name as Printed on Card: _____

Billing Address: _____
(Street, City, State & Zip)

Signature: _____
(Patient or financially responsible party)

Date: _____

*This form will be securely stored in your clinical file and may be updated upon request at any time.
Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation of an appointment less than 48 business hours in advance, or participation in treatment (e.g. appointment or phone session) without payment rendered.*



Patient Name: _____ DOB: _____

NEW PATIENT HEALTH SCREENING

√ all that apply	If you answer "yes" to any question, fully describe below
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have stents?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on dialysis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any shunts in your body?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a cardiac pacemaker?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have an aneurysm clips or coil?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have implanted vagus nerve or deep brain stimulator?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a cochlear implants for hearing?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any other implanted device?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any metallic objects in your body?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have electrodes for monitoring brain activity?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any magnetic implants?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any bullet fragments in your body?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any implanted electrical devices including medication pumps and pacemakers?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have cancer?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have headaches?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a seizure?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever suffered a stroke?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any cardiac disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any infectious disease?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any allergies?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a history of alcohol or drug abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? If yes, how many packs per day? How many years?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcohol? If yes, how many drinks per week?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had any suicide attempts? If yes, how many?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any current legal issues?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an MRI of your brain?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any other medical problems (past or present)?

Describe:

Signature: _____

Date: _____



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MEDICATION REFILL POLICY

- It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
- Medication refills will only be addressed during regular office hours (Monday-Friday 8am-5pm). The urgent care staff will not return any phone calls regarding refills. Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.
- Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.
- Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guaranty that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 3 to 6 months.
- If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.
- New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

Patient Signature

Date



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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

1. You have the right to dignified and respectful care.
2. You have the right to know about and understand your physical condition.
3. You have the right to obtain any information requested by you to give informed consent before any treatment and/or procedure.
4. You have the right, at your own expense, to consult with another practitioner or psychiatrist.
5. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal.
6. You have the right to be treated in a safe environment that is free of physical and psychological threats.
7. You have the right to privacy regarding visitors, mail, and/or telephone conversations.
8. You have the right to expect that all communications and records regarding your care will be held confidential.
9. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice.
10. You have the right to communicate verbally or in writing with anyone outside the practice and to expect that an interpreter will be provided if language is a barrier.
11. You have the right to know the identity, professional status, and institutional affiliation of anyone treating you.
12. You have the right to request an itemized statement of all services provided to you through this practice.
13. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.
14. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

Patient Responsibilities

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.
2. You will be responsible for participating in the development of your plan of care.
3. You will be responsible for attending scheduled therapy and participating in activities prescribed by your treatment plan.
4. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice.
5. You are responsible for following practice rules and regulations.

Concern/Complaint Procedure

We want to hear from you if you have any concerns, complaints, or compliments regarding your treatment and care in our practice. Please inform any staff member. Response to a concern/complaint will take place within 24-48 business hours. Concerns/complaints will be monitored, and the information utilized to improve our program.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.



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HIPAA—PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be disclosed to other healthcare providers for the purpose of providing you with a continuum of quality healthcare.
- Your confidential healthcare information may be disclosed to your insurance provider for the purpose of receiving payment for providing you with healthcare services.
- Your confidential healthcare information may be disclosed to public official or law enforcement agencies in an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be disclosed to other healthcare professionals in the case of a healthcare emergency.
- Your confidential healthcare information may be disclosed to public health organizations or federal organizations in the matter of communicable diseases, defective devices, or a food or medication reaction.
- Your confidential healthcare information cannot be disclosed for purposes other than those, which are outlined in this notice.
- Your confidential healthcare information may only be disclosed after receiving written authorization from you. You have the right to revoke your permission to disclose confidential healthcare information at any time.
- You may be contacted by office personnel to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to restrict the use and disclosure of your confidential healthcare information to family members, friends, or others involved in your healthcare or payment for health care services. However, the practitioner may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of a medical emergency.
- You have the right to receive confidential communication about your healthcare status.
- You have the right to review and request a copy of any and/or all portions of your healthcare information.
- You have the right to request changes be made to your healthcare information.
- You have the right to have a copy of this Privacy Notice upon request.
- This office is required by law to protect the privacy of its patients.
- This office will abide by the terms of this notice. We reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the Privacy Officer of this office and to the Secretary of Health and Human Services if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

Attn: Sean Hughes
Fig Tree Behavioral Wellness, LLC
2211 W. Lincoln St Ste #313
Harlingen, Tx 78552

All complaints will be investigated. No issue will be raised for filing a complaint with this clinic.