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: ___No ___Yes	When?	
List all current medications with dosage:		
Currently seeing a Therapist:____No ____Yes	Therapist:	How long?
History of psychiatric hospitalization or testing: ____No ____Yes When & What for?		
Eating Disorder: ___No ___Yes	Current/how long ago?	
Substance abuse (illicit and/or prescribed drugs/alcohol/tobacco, etc) ___No ____Yes Current/how long ago?		
Suicidal ideations: ___No ____Yes	Current/how long ago?	
Thoughts of harming others ___No ___Yes	Current/how long ago?	

FIGTREE
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Patient Name:_____DOB:_____

NEW PATIENT HEALTH SCREENING

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

Describe surgical history and medical issues:

_____

_____

_____

_____

_____

Signature:_____ Date:_____

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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:_____ Date:_____
(Patient or financially responsible party)

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 Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

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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 9am-5pm). 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 guarantee 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. After the 3rd no call no show, we will discharge you from services and provide a courtesy 30 day fill of your medications except controlled medications. All prescriptions require a follow up appointment every 1 to 3 months.

- Monthly drug screens are be required for controlled medication management.

- 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

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Informed Consent for Psychiatric Medications

PURPOSE OF THIS FORM: This form documents that you and your prescriber have discussed your medication(s) to your satisfaction.

Your prescriber has ordered the following medication(s) and has either told you about the medication(s) or given you written information or both. You are entitled to know the following information before deciding to take the medication(s):

1. What your condition or diagnosis is.
2. What symptoms the medication(s) should reduce and how likely the medications are to work.
3. What your chances are of getting better without the medication(s).
4. What other reasonable treatments are available.
5. The name, dosage, frequency, route of administration and the duration of the prescribed medication(s).
6. Side effects of the medication(s) known to commonly occur.
7. Any special indications about taking the medications.

Medications

- By signing this form, you indicate the medication(s) have been explained to you to your satisfaction.
- Even after signing, you can still refuse any dose or withdraw your agreement completely at any time.
- Upon request, you may receive a copy of this consent form.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I have had the opportunity to receive information about my medication(s) from the prescriber, and **CONSENT** to this treatment. I understant that I can ask questions about my medications at any time. (Informed Consent)

☐ I have had the opportunity to discuss information about the medications with the prescriber, and I **REFUSE** to consent to the medication(s) recommended. I understand that my doctor will continue to offer me the chance to take the medication(s), and information about it, but that I may still refuse the medication(s). (Informed Refusal)

	/ /		/ /
Patient Signature	Date	Provider Signature	Date

If applicable:

Legally Authorized Representative	Relationship to Patient

Revised version 10/26/2017

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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. No Show Policy: 1st No show No Charge, 2nd No Show $100, 3rd No Show $100, 4th
4. No Show $100, After that, the patient will be discharged from services and will be responsible for the
5. balance.
6. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice.
7. 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.