TREY AOUEILLE, M.D.
1101 S. Capital of Texas Highway
Building A, Suite 200
Austin, TX 78746
Office: (512)327-9400
Fax: (512)329-5522

PSYCHIATRIC AND MEDICAL HISTORY FORM

Patient's name:		**Date of Birth:**	
Current Weight:		**Current Height:**	_____ **feet** _____**inches**

Please give a brief reason for your visit:_____

_____

_____

Current Therapist:		Ph:	Fax:

List any past psychiatric care and medications prescribed:

Date	**Psychiatrist (Name, City and State)**	**Diagnosis / Medications prescribed**

List any past psychiatric hospitalizations or substance abuse treatment and their dates:

Date	**Facility (Name, City and State)**	**Type of Treatment**

Please check if you have been diagnosed with any of the medical conditions listed below:

☐ High Blood Pressure ☐ Seizures ☐ Asthma ☐ High Cholesterol ☐ Head Injury
☐ Cancer ☐ Heart Disease ☐ Migraine ☐ Liver Disease ☐ Diabetes
☐ Glaucoma ☐ Kidney Disease ☐ Thyroid Problems ☐ Chronic Pain ☐ Sleep Apnea
☐ Other Serious Illness(es): _____

Are you currently under medical care for any reason? ☐ **Yes** ☐ **No**

If yes, please explain: _____

_____

List all medications, herbs and nutritional supplements you are now taking: (continue on back if needed…)

Medication, Herb or Supplement:	**Dose (mg's, etc.):**	**Prescribed by:**

Allergies:			
Primary Care Dr.:		Ph:	Fax:

WOMEN: Please check any of the following that apply: ☐ I am pregnant (or trying to become pregnant)

☐ I have regular menstrual periods ☐ I am perimenopausal ☐ I am menopausal ☐ I had a hysterectomy

Do you experience variations in mood or anxiety level related to your menstrual period? ☐ Yes ☐ No

Signature:		**Date:**	

PATIENT CONTACT INFORMATION

Patient First Name: _____ **MI:** _____ **Last:** _____

DOB: _____ Age: _____ Gender: ☐M ☐F Marital Status: ☐S ☐M ☐D

Parent(s) if minor: _____

Student Status: □ Non-student □ Full-Time □ Part-Time School Name: _____

Other Family Members: _____

Employer: _____ Occupation: _____

Email: _____ ☐@gmail.com ☐@yahoo.com ☐Other: @_____

Preferred Contact Phone #: (_____) _____ **Ok to leave message?** ☐Yes ☐No

Secondary Contact Phone #: (_____) _____ **Ok to leave message?** ☐Yes ☐No

Current Mailing Address: _____ Apt #: _____

City/ST: _____ Zip: _____

New Mailing Address (eff: _____)

Address: _____ Apt #: _____

City/ST: _____ Zip: _____

New Mailing Address (eff: _____)

Address: _____ Apt #: _____

City/ST: _____ Zip: _____

Referred by: _____ Reason for Visit: _____

Family Physician: _____ Allergies: ☐None or _____

Pharmacy Information:

Pharmacy Name: _____

Address (or Intersection): _____

I authorize Dr. Trey Aoueille's office to electronically obtain access to my prescription history from participating pharmacies through the Surescripts Network.

_____ _____

Signed Date

_____ Relationship to Patient:

Printed Name ☐ Patient ☐ Parent / Guardian

_____ _____

Staff Member / Witness Signature Date Staff Member / Witness Printed Name

Emergency Contact Information

Emergency Contact Name: _____

Preferred Contact Phone #: (_____) _____ Ok to leave message? ☐Yes ☐No

Secondary Contact Phone #: (_____) _____ Ok to leave message? ☐Yes ☐No

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PATIENT FINANCIAL INFORMATION

Dr. Aoueille is not a network provider for any insurance companies and payment in full is due at the time services are rendered. If you would like, we're happy to provide you with a walk out receipt to use in filing for any out of network benefits you may have with your insurance company. *Insurance companies do not usually cover the entire cost of the fees.* Any financial concerns should be discussed with the Doctor prior to services being rendered. If this agreement is not met, measures to collect the outstanding balance will be taken through all appropriate legal means.

RATES & FEES:

Initial Diagnostic Consultation:	90 minutes	$600.00
Office or Phone Consultations:	30 minutes	$200.00
	60 minutes	$350.00
	90 minutes	$525.00

APPOINTMENTS:

- Courtesy appointment reminders are made 3 business days in advance of your appointment.
- Appointments must be cancelled 2 business days in advance to avoid a missed appointment fee.
- **Patients who miss their appointments or fail to cancel the appointment 2 business days in advance may be financially responsible for the full fee of the appointment.**
  Please note: Insurance companies do not reimburse for missed appointments.
- **Missed appointment fees must be paid prior to the next appointment.**
- Patients who are consistently unable to keep their scheduled appointments will receive notification of discontinuation of services via postal service.

Patient Name: _____

Responsible Party Name (if different from patient): _____

Billing Address: _____

City/ST: _____ Zip: _____

Preferred Contact Phone #:(_____)_____ ☐Home ☐Cell ☐Work ☐Ok to leave message?

To keep a credit card on file, please provide a credit card number below:

☐MC ☐Visa ☐Amex ☐Discover CC #:_____

Expiry (MM/YY): ____/____ Billing address for above card: _____

Security Code: _____ City, State: _____ Zip Code: _____

Email (if you'd like a credit card receipt emailed to you): _____@_____

By signing below, I acknowledge that I have read the above and agree to be personally responsible for all charges and I give my consent for medical treatment.

In agreement: _____ _____
Responsible Party Signature (Patient or Parent/Guardian) Date

Reviewed by: _____ _____
Office Staff Signature Date

I appreciate the opportunity to be of service to you. If you have questions, concerns, or suggestions regarding my practice, please feel free to discuss them with me. I'm always eager to hear your comments and will gladly answer any of your questions.

Complaints about physicians, as well as other licenses and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners: Attn: Investigation, 1812 Centre Creek Dr., Suite 300, POB 149134, Austin, TX 78714-9134. Assistance in filing a complaint is available by calling the following telephone number: (800)201-9353.

Se pueden presenter quejas acerjas acerca de medicos, asi tambien como de otras personas autorizadas y registradas por la Junata de Examinadores Medicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes medicos y acupenteristas, para su investigacion, en la siguente direccion: Texas State Board of Medical Examiners: Attn: Investigation, 1812 Centre Creek Dr., Suite 300, POB 149134, Austin, TX 78714-9134. Se pueden obtener ayunda para presenter una queja llamando al sigiente numero telefonico: (800)201-9353.

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CLIENT EMAIL & APPOINTMENT REMINDERS VIA TEXT CONSENT FORM

(Please complete if you'd like to correspond via email or receive appointment reminders via text message.)

Patient Name: _____ DOB: _____

Parent(s)/Legal Guardian Name if minor: _____

HIPAA (Health Insurance Portability and Accountability Act) was passed by the U.S. government in 1996 to establish privacy and security protections for health information. In their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. (You can find this information in a pdf (pg. 5634) on the U.S. DHHS website: http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf.)

Per these guidelines, the following are the risks and our policies for sending and/or receiving unencrypted email:

- Emails should include only routine matters that don't require an immediate response (like prescription requests, appointments, billing questions, etc.).
- **EMAILS ARE NOT APPROPRIATE FOR USE IN AN EMERGENCY.**
- Our office will try to reply to all emails within one business day, but we can't be responsible for technical issues or delays in message delivery by the service provider.
- **Please keep in mind that emails are not completely secure.**
- Our office is dedicated to keeping your medical record information confidential; however, due to the nature of email, third parties may have access to messages. Some popular email services (like Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email. (However, when our office sends a document attached to an email with sensitive information, our office will send it as an encrypted pdf protected with a passcode. A separate email will follow with the passcode to open your document.)
- Once the email is received by you, someone may be able to access your email account and read it.
- **When communicating from work (or with a work email), you should be aware that some companies consider email corporate property and your messages may be monitored.**
- Our office staff prints out all emails and files them in the medical record. Office staff may read email messages.
- Our office will not correspond via text message except by way of sending an appointment reminder two (2) business days prior to your scheduled appointment (if consented to below). Any replies to this text message will be converted into an email on our end.

_____**I understand the risks of unencrypted email and hereby give permission to Dr. Aoueille's office to send personal health information via unencrypted email to the following email address:**

_____@_____

_____**I authorize Dr. Aoueille's office to send appointment reminders via text message to (and any number forwarded from or transferred to) the following cell phone number:**

(_____) _____ - _____ ☐ AT&T ☐ Sprint ☐ Verizon ☐ T-Mobile ☐ _____

I understand that I may terminate this authorization by providing written revocation to Dr. Aoueille's office. I understand that I am responsible for updating Dr. Aoueille's office of any changes to my email address and/or cell phone number as listed above.

_____ _____
Signed Date

_____ Relationship to Patient:
Printed Name ☐ Patient ☐ Parent / Guardian

_____ _____
Staff Member / Witness Signature Date Staff Member / Witness Printed Name

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RECEIPT AND ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and/or have been given an opportunity to read a copy of Dr. Bernard Aoueille, III, M.D.'s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Aoueille's office at (512)327-9400.

Patient Name: _____ DOB: _____

_____ _____
Signature Date

_____
Printed Name

Relationship to Patient:
☐ Patient
☐ Parent / Gaurdian
☐ Other: _____

_____ _____
Witness Signature Date

□ Patient refused to sign Acknowledgment Receipt due to the following: