PLEASE READ THESE CLINIC RULES

You are expected to make your payment or co-payment *before* seeing the physician. We cannot allow the practice of leaving without paying after seeing the physician and obtaining a prescription. If you are unable to pay, it needs to be discussed *before and not after* the appointment.

With the shortage of psychiatrists in the Permian Basin, many people seeking help must wait to be seen. Under these circumstances we cannot allow unnecessary waste of clinic time.

We do not double/triple book patients and when you fail to come, the time set apart for you goes to total waste. In the present situation we simply cannot let that happen. The following steps will be implemented to minimize the chances of this happening.

All appointments will be reconfirmed before 1:00 PM the day before your appointment. If we are unable to reach you after repeated attempts, we will have to cancel the appointment and give that time to someone else. You may want to leave one or more extra telephone numbers for us to call if you cannot be reached.

After confirming the appointment, if you fail to come you will be billed for the wasted time. Insurance companies refuse to pay for missed appointments which will make you personally responsible for the payment.

The secretary will not automatically reschedule you after a missed appointment; you need to contact the clinic manager, Laura Mathew, at 617-3855 after 5:00 PM to discuss your options.

Repeated cancellation of appointments for whatever reason may result in discharge from the clinic. Every effort will be made to work with you and ample warnings given before such a drastic step is taken.

The practice of missing appointments and asking for medicines to be called in to the pharmacy will not be allowed. In most cases you will need to be seen in the clinic first before any prescriptions are provided. We may make exceptions under special circumstances after detailed discussions with the clinic manager.

After missing an appointment you cannot come late and expect to be seen without prior arrangement. In order to fit you in, we will have to cut into someone else's time which will not be fair to them.

We cannot replace lost or stolen prescriptions or medicines especially if it involves controlled drugs, even if you produce a police report.

We are in the business of helping people and every effort will be made to accommodate your special needs and special circumstances. At the same time we also have an obligation to other people in need, both current and future patients. This forces us to be firm and to take drastic steps although we dislike taking such actions more than anyone else.

Thank you.

Roy J. Mathew, MD
Brain and Behavior Clinic

Roy J. Mathew, MD, DPM, FRC Psych
Brain and Behavior Clinic
3425 Caldera Blvd.
Midland, TX 79707

Telephone (432)617-3855
Fax (432)617-3840
E-mail: ljmathew@sbcglobal.net

Consent

- *Brain and Behavior Clinic deals exclusively with psychiatry disorders and is not responsible for the diagnosis and treatment of non-psychiatric (physical) disorders. This also includes neurological disorders such as seizures. It is important that you report all of your medical history to the Brain and Behavior Clinic, and that you have a primary care physician following your physical disorders.*
- *It is important that you report all the medications that you are taking because some drugs can have serious interactions with other drugs you take. Brain and Behavior Clinic cannot be responsible for medications you receive from other sources and their interactions with the medicine you receive from the Brain and Behavior Clinic, if you do not report that you are taking the other drugs. Whenever you are in doubt about the drugs interaction, you should discuss the matter with the Brain and Behavior Clinic physician.*
- *Brain and Behavior Clinic is not open after hours, Sundays, and holidays. In the case of an emergency you must go to an emergency room or call 911.*
- *Please contact the Brain and Behavior Clinic for medications refills at least 1 week ahead of time.*
- *All appointments will be re-confirmed; if you do not show up for a confirmed appointment you will be responsible for the bill personally and you run the risk of being discharged from our care. Your insurance will not pay for a missed appointment. Please call if you must cancel appointments.*

I have read the above statement and understand them. I was given the opportunity to discuss anything I could not understand and I agree to abide by them.

*Signature*___________________________ *Date*____________________

*Witness Signature*___________________ *Date*_____________________

Medication Policy for Brain and Behavior Clinic

As your physician I am responsible for prescribing medications for you. However I cannot be responsible for getting your insurance to pay for the medications. Getting prior authorizations from various insurances has become a very time consuming task for which we are not compensated. Our policies regarding refills and prior authorizations are given below. Please read this carefully and feel free to ask questions.

- Please allow 3 days for us to give you refills from the day you call.
- Drug diversion from physician's offices and pharmacies has become a serious problem and licensing bodies and law enforcement agencies require us to be very strict about this. We cannot replace prescriptions and medicines if you lose them or if they are stolen. You will have to take the necessary precautions. This is especially true for controlled substances. Producing a police report will not change this policy.
- Getting your insurance to pay for your medicine is primarily your responsibility; we will be pleased to do what we can to assist you. You must call your insurance company to begin prior authorization if needed. Kindly ask your insurance to fax us the specific form that they may want us to complete. Neither the pharmacy nor the physician can do this; you will have to make the call.
- Some insurance companies require urine drug screening before they pay for certain medicines. If your insurance requires this, inform us about it. We will give you a time to come to the clinic and to provide us with a urine sample. You cannot send the urine sample through someone else. You also will have to provide us with the names of other medicines including over the counter ones you may have taken and certain food items you may have consumed. The drug screen will show if you are indeed taking the medicines you are prescribed and also any drugs you may have abused. We will send the urine sample to a lab and usually we will get the results back within one week. If you do not want to do the urine drug screen or do not want to wait a week for the result you will have to pay for the medicines yourselves.
- Please do not ask your pharmacy to fax us refill requests. We will not give you a refill unless you ask us for a refill 3 days ahead of time. Please leave us a message with your name, date of birth, your telephone number, and the telephone number of your pharmacy. Pharmacies often make mistakes and therefore we will not automatically fill any requests they make. If you choose to use a prescription mail in service discuss this with us in advance. You may mail the prescription to your insurance. We will not do this for you; you will have to do it yourself.
- If your insurance refuses to pay for the medicine we prescribed, find out from them which comparable medicine they will pay for. We will change the prescription, if possible. Please give us the old unused prescription before you get a new one from us. We will try to work with you to find an acceptable solution. However if your insurance flat out refuses to pay for your medicine we will not be able to appeal their decision; often this is very time-consuming and in most cases, unsuccessful.
- If you have questions please call Laura after 5PM at 617-3855.

Roy J. Mathew, MD

December 2014

Brain and Behavior Clinic/Roy J. Mathew, M.D.

REGISTRATION FORM

(Please Print)

Today's date:					Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First name:	Middle name:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (Check One) Single / Mar / Div / Sep / Wid
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐M ☐ F

Street address:	Social Security no.:	Home phone no.:

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Chose clinic because/Referred to clinic by (please check one box): Looking for psychiatrist	☐ Dr.	☐ Insurance Plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:

Is this person a patient here? ☐ Yes ☐No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Roy J. Mathew, M.D. or insurance company to release any information required to process my claims. I understand if I am not covered by insurance I am responsible for my entire medical bill and agree to pay all charges on time. I also agree to pay all legal fees associated with collection of unpaid medical fees. I understand this statement and have had my questions answered.

Patient/Guardian signature: ______________________ ***Date:*** ____________

Original Date:
Dates Revised:

BRAIN AND BEHAVIOR CLINIC/ROY J. MATHEW, M.D.
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Caffeine	☐ None	☐Coffee	☐ Tea	☐Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Pregnancy	Is there a chance that you are pregnant?				☐ Yes	☐ No
	Are you breast feeding?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No