STANBRO HEALTHCARE GROUP LLC

Thank you for choosing Stanbro Healthcare Group! Per your request, I am sending you the new patient intake packet.

We have a detailed intake process that is designed to improve efficiency and provide the best service possible. In order to set up your appointment and receive an appropriate evaluation, we ask that you carefully fill out all of the enclosed forms as completely as possible and return them via email, fax or US mail to the address provided below. Once we receive your packet, our team will review the information for the appropriate clinician and appointment. You will be contacted by one of our placement team members as soon as an appointment date becomes available.

Enclosed are the following:

1. Demographic Sheet
2. Adult History Questionnaire
3. Release of Information
4. Consent for Treatment & Patient Rights

Please note: We are not contracted with and do not accept Medicare, even if you have secondary coverage.

Please include when returning:

1. A copy of the front and back of your insurance card(s)
2. If possible, a copy of your most recent physical exam, immunization record and relevant lab results

Methods for returning your completed packet:

- Fax: 405.341.2672
- Email: Info@StanbroHealthcareGroup.com
- US Mail: 2000 East 15th Street, Suite 400A, Edmond, OK 73013
- Coming soon to our website: StanbroHealthcareGroup.com

Again, thank you for choosing Stanbro Healthcare Group. We are honored to serve you.

Sincerely,

The SHG Team

STANBRO HEALTHCARE GROUP LLC

INFORMATION YOU SHOULD KNOW ABOUT
MENTAL HEALTH INSURANCE COVERAGE

Stanbro Healthcare Group provides in-network services for a wide variety of insurance providers. We also provide documentation of billing and services if you prefer out-of-network coverage. We are not contracted with and do not accept Medicare.

Please note that mental health coverage is frequently very different from medical coverage. Also benefits allowed by your insurance provider are frequently subject to change beyond our control. We strongly encourage you to contact your insurance provider or benefits administrator to verify the specific mental health services allowed by your insurance plan.

- **Verification of mental health benefits and preauthorization for services:** As a courtesy to you, we obtain information regarding your mental health benefits and preauthorization before your first visit. You will be provided with the information we are given by your health plan and we encourage you to refer to your policy manual or call your plan to confirm the information provided to us.

- **Co-payments:** Costs are often a percentage of the charges incurred instead of a fixed dollar amount. Information about co-payments for mental health services is rarely listed on the insurance card and is obtained by calling the plan.

- **Deductibles:** Mental health services are often separate and in addition to the medical deductible outlined by your insurance plan. If the deductible required by your plan has not been reached, we may need to collect the full amount for services at the time of your appointment.

- **Referrals:** If you are covered by a managed care insurance plan which requires referrals, you must obtain referral forms from your primary care physician prior to your visit (Tricare plans require this referral). *Please note that a written referral is a requirement of the insurance company and that we must adhere to the plan's administrative requirements in order to receive payment on your behalf.*

- **Limits:** Frequently, mental health benefits are limited per calendar or plan year. Please consult your policy manual regarding your maximum calendar year or plan year benefits.

- **Testing:** Neuropsychological, psychological, and developmental testing are frequently requested by our clinicians and referrals will be made for the needed testing. Most insurance companies limit the number of testing hours covered. Please contact your insurance provider prior to the referral being placed to verify limits and coverage.

STANBRO HEALTHCARE GROUP LLC

DEMOGRAPHICS

Patient's Name (Last, First, MI) _____ Patient's Date of Birth _____

Sex _____ Gender Identity _____ Race _____ Social Security Number _____

Mailing Address _____

Home Telephone _____ Cell Number _____

Email Address _____

Preferred method of contact for appointment reminders and other electronically generated messages
□Voice □ Text □ Email

REASON FOR SEEKING MENTAL HEALTH SERVICES (check all that apply)

□ Behavior Problems	□ Attention Deficit/Hyperactivity Disorder	□ Depression
□ Anxiety	□ PTSD	□ PANDAS/PANS
□ Obsessive Compulsive Disorder	□ Oppositional Defiant Disorder	□ Suicidal Ideation
□ Homicidal Ideation	□ Visual Hallucinations	□ Audible Hallucinations
□ Bipolar Disorder	□ Substance Use/Abuse	□ Other

WHO REFERRED YOU TO STANBRO HEALTHCARE GROUP?

□ Primary Care Physician	□ Specialist (indicate specialty) _____	□ School
□ Therapist/Counselor	□ Social Worker/Case Worker	□ Emergency Room
□ General Hospital Discharge	□ Psychiatric Hospital Discharge	□ Self-referred

INSURANCE INFORMATION

Primary Insurance Company: _____ Telephone Number _____
Policy/Identification Number: _____
Group Name: _____ Group Number: _____
Subscriber's/Policy Holder's Name: _____
Subscriber's/Policy Holder's Date of Birth: _____ Social Security Number: _____
Secondary Insurance Company: _____ Telephone Number _____
Policy/Identification Number: _____
Group Name: _____ Group Number: _____
Subscriber's/Policy Holder's Name: _____
Subscriber's/Policy Holder's Date of Birth: _____ Social Security Number: _____

DEMOGRAPHICS CONTINUED

FINANCIALLY RESPONSIBLE PARTIES (GUARANTORS)

Primary Guarantor's Name: _____
Relationship to Patient: _____
Address (if different from patient): _____

_____
Employer: _____
Address: _____
Home Telephone: _____ Cell Number: _____
Work Telephone: _____ Email: _____
Date of Birth: _____ Social Security Number: _____
Secondary Guarantor's Name: _____
Relationship to Patient: _____
Address (if different from patient): _____

_____
Employer: _____
Address: _____
Home Telephone: _____ Cell Number: _____
Work Telephone: _____ Email: _____
Date of Birth: _____ Social Security Number: _____

ARE THERE OTHER FAMILY MEMBER'S WHO ARE CURRENT PATIENTS AT STANBRO HEALTHCARE GROUP?
□ Yes (please list below) □ No

_____
_____

Method for returning your completed packet:

- Fax: 405.341.2672
- Email: Info@StanbroHealthcareGroup.com
- US Mail: 2000 East 15th Street, Suite 400A, Edmond, OK 73013
- Coming soon to our website: StanbroHealthcareGroup.com

STANBRO HEALTHCARE GROUP LLC

ADULT HISTORY QUESTIONNAIRE

Please complete all information on this form and bring it to your first visit. It may seem long, but most of the questions require only a check, so it will go quickly! You may need to ask family members about the family history.

Patient Name _____ Date of Birth _____ Date _____

Do you give permission for ongoing regular updates to be provided to your primary care physician? □ No □ Yes

Current Therapist/Counselor _____ Phone Number _____

What are the problem(s) for which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals? _____

_____

_____

_____

CURRENT SYMPTOMS CHECKLIST: (check once for any symptoms present, twice for major symptoms)

□ Depressed mood	□ Racing thoughts	□ Excessive worry
□ Unable to enjoy activities	□ Impulsivity	□ Anxiety attacks
□ Sleep pattern disturbance	□ Increased risky behavior	□ Avoidance
□ Loss of interest	□ Increased libido	□ Hallucinations
□ Concentration/forgetfulness	□ Decreased need for sleep	□ Suspiciousness
□ Change in appetite	□ Excessive energy	□ Suicidal ideations
□ Excessive guilt	□ Increased irritability	□ Homicidal ideations
□ Fatigue	□ Crying Spells	□ Other _____

SUICIDE RISK ASSESSMENT

Have you ever had feelings or thoughts that you didn't want to live? □ No □ Yes

If yes, please answering the following. If no, please skip to the next section.

Do you *currently* feel that you don't want to live? □ No □ Yes

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

_____

On a scale of 1 to 10, (ten being strongest), how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

_____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

SUICIDE RISK ASSESSMENT (CONTINUED)

Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
_____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? □ No □ Yes
If yes, please explain. _____

PAST MEDICAL HISTORY

Current Weight: _____ Current Height: _____

Allergies: _____

List *ALL* current prescription medications and how often you take them (if none, write "None"):

Medication Name	Dosage	Frequency	Estimated Start Date

Current over-the-counter medications, supplements, vitamins, herbs, etc.: _____
_____

Current medical problems: _____
_____

Past medical problems, non-psychiatric hospitalization or surgeries: _____
_____
_____

Have you ever had an EKG? □ No □ Yes If yes, when: _____
Was the EKG: □ Normal □ Abnormal □ Unknown

For women only: Date of last menstrual period: _____
Are you currently pregnant or do you think you might be pregnant? □ No □ Yes
Are you planning to get pregnant in the near future? □ No □ Yes
Birth control method: _____
How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? □ No □ Yes
Date and place of last physical exam: _____

PERSONAL AND FAMILY MEDICAL HISTORY

Thyroid Disease	□ You	□ Family	Family Member: _____
Anemia	□ You	□ Family	Family Member: _____
Liver Disease	□ You	□ Family	Family Member: _____
Chronic Fatigue	□ You	□ Family	Family Member: _____
Kidney Disease	□ You	□ Family	Family Member: _____
Diabetes	□ You	□ Family	Family Member: _____
Asthma/Respiratory	□ You	□ Family	Family Member: _____
Stomach/Intestinal	□ You	□ Family	Family Member: _____
Cancer (type) _____	□ You	□ Family	Family Member: _____
Fibromyalgia	□ You	□ Family	Family Member: _____
Heart Disease	□ You	□ Family	Family Member: _____
Epilepsy/Seizures	□ You	□ Family	Family Member: _____
Chronic Pain	□ You	□ Family	Family Member: _____
High Cholesterol	□ You	□ Family	Family Member: _____
High Blood Pressure	□ You	□ Family	Family Member: _____
Head Trauma	□ You	□ Family	Family Member: _____
Liver Problems	□ You	□ Family	Family Member: _____
Other	□ You	□ Family	Family Member: _____

Is there any additional personal or family medical history? □ No □ Yes
If yes, please explain: _____

When your mother was pregnant with you, were there any complications during the pregnancy or birth? □ No □ Yes
If yes, please explain: _____

PAST PSYCHIATRIC HISTORY

Outpatient treatment? □ No □ Yes If yes, please describe when, by whom, and nature of treatment:

REASON	DATES TREATED	BY WHOM

Psychiatric Hospitalization? □ No □ Yes If yes, please describe for what reason, when and where.

REASON	DATE HOSPITALIZED	WHERE

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write what you do remember).

Antidepressants	**Dates**	**Dosage**	**Response/Side-Effects**
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Serzone (nefazodone)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			

Mood Stabilizers	**Dates**	**Dosage**	**Response/Side-Effects**
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

Antipsychotics/Mood Stabilizers	**Dates**	**Dosage**	**Response/Side-Effects**
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			

Sedative/Hypnotics	**Dates**	**Dosage**	**Response/Side-Effects**
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			

Past Psychiatric Medications (continued)

ADHD Medications	Dates	Dosage	Response/Side-Effects
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			

Antianxiety Medications	Dates	Dosage	Response/Side-Effects
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Tranxene (clorazepate)			
Busbar (buspirone)			

YOUR EXERCISE LEVEL

Do you exercise regularly? □ No □ Yes
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family been diagnosed with or treated for:

□ Bipolar Disorder □ Schizophrenia □ Depression □ Violence
□ Post-Traumatic Stress □ Anxiety □ Alcohol Abuse □ Other
□ Anger □ Other Substance Abuse □ Suicide

If yes, who had each problem? _____

Has any family member been treated with psychiatric medication? □ No □ Yes
If yes, who was treated, what medications did they take, and how effective was the treatment? _____

SUBSTANCE USE

Have you ever been treated for alcohol or drug use or abuse? □ No □ Yes
If yes, for which substances? _____
If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you should cut down on your drinking or drug use? _____
Have people annoyed you by criticizing your drinking or drug use? □ No □ Yes
Have you ever felt bad or guilty about your drinking or drug use? □ No □ Yes
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? □ No □ Yes
Do you think you may have a problem with alcohol or drug use? □ No □ Yes

Substance use (continued)
Have you used any street drugs in the past 3 months? □ No □ Yes
If yes, which ones? _____
Have you ever abused prescription medication? □ No □ Yes
If yes, which ones and for how long? _____

Have you ever tried the following:

Methamphetamine	□ No	□ Yes	If yes, how long and when did you last use? _____
Cocaine	□ No	□ Yes	If yes, how long and when did you last use? _____
Stimulants (pills)	□ No	□ Yes	If yes, how long and when did you last use? _____
Heroin	□ No	□ Yes	If yes, how long and when did you last use? _____
LSD/Hallucinogens	□ No	□ Yes	If yes, how long and when did you last use? _____
Marijuana	□ No	□ Yes	If yes, how long and when did you last use? _____
Pain Killers (not at prescribed)	□ No	□ Yes	If yes, how long and when did you last use? _____
Methadone	□ No	□ Yes	If yes, how long and when did you last use? _____
Tranquilizer/Sleeping	□ No	□ Yes	If yes, how long and when did you last use? _____
Alcohol	□ No	□ Yes	If yes, how long and when did you last use? _____
Ecstasy	□ No	□ Yes	If yes, how long and when did you last use? _____
Other _____	□ No	□ Yes	If yes, how long and when did you last use? _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

TOBACCO HISTORY

Have you ever smoked cigarettes?	□ No	□ Yes		
Currently?	□ No	□ Yes	How many packs per day? _____	How many years? _____
In the past?	□ No	□ Yes	How many years? _____	When did you quit? _____
Do you use chewing tobacco?	□ No	□ Yes	How often per day? _____	How many years? _____

FAMILY BACKGROUND AND CHILDHOOD HISTORY
Were you adopted? □ No □ Yes Where did you grow up? _____
List your siblings and their ages: _____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents divorce? □ No □ Yes If so, how old were you when they divorced? _____
If your parents divorced, who did you live with? _____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? □ No □ Yes
Who and when? _____

TRAUMA HISTORY
Do you have a history of being abused emotionally, sexually, physically or by neglect? □ No □ Yes
Please describe when, where and by whom: _____
_____

EDUCATIONAL HISTORY

Highest grade completed? _____ Where? _____
Did you attend college? □ No □ Yes Where? _____
What is your highest educational level or degree attained? _____

OCCUPATIONAL HISTORY

Are you currently: □ Working □ Student □ Unemployed □ Disabled □ Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? □ No □ Yes If so, what branch and when? _____
Honorable discharge? □ No □ Yes Other discharge type _____

RELATIONSHIP HISTORY AND CURRENT FAMILY

Are you currently: □ Married □ Partnered □ Divorced □ Single □ Widowed
How long? _____
If not married, are you currently in a relationship? □ No □ Yes If yes, how long? _____
Are you sexually active? □ No □ Yes
How would you identify your sexual orientation?
□ Straight/Heterosexual □ Lesbian/Gay/Homosexual □ Bisexual □ Transsexual
□ Unsure/Questioning □ Asexual □ Other □ Prefer not to answer
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other: _____

_____

_____

Have you had any prior marriages? □ No □ Yes If so, how many? _____ How long? _____
Do you have children? □ No □ Yes If yes, list ages and gender: _____
Describe your relationship with your children: _____

_____

List everyone who currently lives with you: _____

_____

Is your spouse authorized to act on your behalf (make appointments, pick-up prescriptions, records, etc.)? □ No □ Yes
If yes, please print spouse's name: _____

LEGAL HISTORY

Have you ever been arrested? □ No □ Yes
Do you have any pending legal problems: □ No □ Yes

SPIRITUAL LIFE

Do you belong to a particular religion or spiritual group? □ No □ Yes
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you?
□ More helpful □ More stressful

Is there anything else that you would like us to know? _____

_____

_____

_____

_____ _____ _____
Printed Name of Patient Signature Date

STANBRO HEALTHCARE GROUP LLC

AUTHORIZATION OF RELEASE OF INFORMATION

I, _____, hereby consent to and to authorize Stanbro Healthcare Group to
□ release to □ release from:

_____ _____
Physician Name Facility/Group Name

_____
Address, City, State, Zip

_____ _____
Telephone Number Fax Number

The following information:

□ Psychiatric Records □ Psychological/Educational Assessments □ Psychosocial Assessment
□ ARD Materials □History of Allergies □ Last Report Card, Consumer's Forms
□ Medication/Lab Data EKG □ Last Physical Examination □ Immunization Records
□ Entire Health Record □ Other: _____

I also understand that my insurer requires information regarding my child's treatment; I agree to have this information released as requested. I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to the information already retained; used or disclosed in response to this authorization. The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal law (42CFR Part 2). Federal law prohibits anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the patient or is permitted by 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

_____ Initial Here: I understand that if my records are released, I will be charged a $25.00 Records Request Fee, payable prior to the release of the requested records. Your health insurance coverage will not reimburse you for this charge.

_____ _____
Printed Name of Patient Date of Birth

_____ _____
Social Security Number Expiration Date (if not one year of signature date)

_____ _____
Patient Signature Date

_____ _____
Witness Date

Stanbro Healthcare Group
2000 East 15th Street, Suite 400A
Edmond, OK 73013
405.341.1697 f405.341-2672

HIPPA Document
6 Year Retention
Scan to patient chart

STANBRO HEALTHCARE GROUP LLC

CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES

I seek to receive outpatient mental health services at Stanbro Healthcare Group. Outpatient mental health services include any or a combination of the following: evaluation, individual therapy, group therapy, family therapy, referral to psychological or neuropsychological testing, and medications. I consent to participate in program activities directly associated with my mental health evaluation and treatment, and as appropriate, to involve my family members. I authorize Stanbro Healthcare Group to review my medical record for teaching purposes. I understand that all the personal information that I provide about myself and my family will remain confidential and any published data will keep my identity and my family's identity confidential.

Psychiatric assessment and evidence-based treatment includes a variety of methods aimed at two objectives:

1. Reducing or eliminating disturbing symptoms, and
2. Helping your child achieve greater psychological comfort, improved behavioral functioning and/or self-control and achieve better adjustment to life circumstances. Treatment generally consists of therapy and/or prescription of medications, psycho-education, and modification of health-related behaviors.

Please note: The purpose of the evaluation is not meant to be used for any type of court or forensic evaluation, nor is it meant to be a substitute for a disability determination.

No patient will be required to take medication and always have the right to either refuse and/or request to be taken-off of any medication at any time.

With this consent for treatment, you acknowledge that any medication prescribed for you will be taken *exactly* as prescribed. You should not change the amount or frequency of the medication without consulting first with your medical provider. It is important to consult with your medical provider *before* stopping any prescribed medication. You will complete all lab work that is requested by your medical provider. Because some medications may interact negatively with other drugs (e.g. other prescribed medications, over-the-counter substances, herbs, vitamins, illegal drug, etc.) you MUST inform your medical provider about any of these currently being taken. Please notify your medical provider if you think you are pregnant.

DISCONTINUATION OF TREATMENT POLICY

NO SHOW POLICY: All new and follow up appointments must be cancelled at least 24 hours prior to the appointment time. Cancellation or reschedule requests on the day of the appointment are considered NO SHOW appointments.

Please be aware that Stanbro Healthcare Group may discontinue your treatment for any of the following reasons:

- ✓ Achievement of treatment goals.
- ✓ Failure to appear for two or more appointments within a three-month period, without at least a 24-hour notification.
- ✓ Being consistently late for appointments or consistently cancelling appointments.
- ✓ Not participating in treatment for a period of 90 consecutive days.

By signing below, you are giving consent for treatment.

Printed Name of Patient	Signature	Date

STANBRO HEALTHCARE GROUP LLC

PATIENT RIGHTS

As a patient at Stanbro Healthcare Group (SHG), you have a right:

- To be treated with dignity and respect.
- To receive the most appropriate treatment regardless of age, gender, race, religion, sexual orientation, national origin or method of payment.
- To know what fees will be charged for your treatment in advance.
- To know the name and professional status of those persons providing your treatment.
- To participate in the development of a comprehensive Individual Treatment Plan (ITP) and to receive treatment according to this treatment plan.
- To be informed of any possible side effects of prescribed medication.
- To privacy and confidentiality concerning your treatment and medical record. Information from your record will be released only with your written permission. However, all SHG staff involved with your treatment will share information with one another.
- To be free from physical, mental and sexual abuse or harassment.
- To be free from intrusive research.
- To have your concerns addressed in a timely manner, generally at the point of service, without fear of retaliation.
- To file a confidential verbal or written complaint regarding your treatment. An impartial investigation will be initiated within 24 hours of receipt of complaint. All complaints will be resolved within 30 days of the date of complaint. To file a complaint, you may:
    1. Start informally by contacting the Team Leader or any staff member. If your claim is not resolved in five (5) business days, you may contact;
    2. The Practice Manager at 405-341-1697, extension 105 or the Medical Director at 405-341-1697, extension 115.

As a patient at Stanbro Healthcare Group (SHG), you have a responsibility:

- To keep your appointment or notify us of any changes as early as possible.
- To collaborate in the development of your Individualized Treatment Plan (ITP).
- To work toward the achievement of your treatment goals.
- To be honest with staff by sharing anything that might impact upon your treatment.
- To obtain all necessary treatment referrals/prior authorizations from your primary care physician and from your health plan.
- To pay your fees on time/or discuss with staff any related financial difficulties.
- To promptly provide information regarding changes in health insurance, address, phone numbers and/or email address.
- To let staff know if you are dissatisfied in any way with your treatment.
- To inform staff of your desire to terminate treatment, especially if you have not achieved your treatment goals.

Printed Name of Patient	Signature	Date

STANBRO HEALTHCARE GROUP LLC

CONSENT, AUTHORIZATION AND ASSIGNMENT OF INSURANCE AGREEMENT

I, _____, hereby authorize Stanbro Healthcare Group to apply for benefits on my behalf for services rendered. I request that payments be made directly to Stanbro Healthcare Group. I affirm that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to any insurance company. A copy of this consent, authorization and assignment agreement may be used in place of the original. This agreement will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, *whether or not paid by my medical insurance*. I agree to assume responsibility for all charges incurred, should collection of this balance become necessary, including court costs and attorney's fees. I also understand that I will be charged a $50 Returned Check Fee for any checks returned for non-payment from my bank. Additionally, I understand that I am financially responsible for all non-appointment services, such as report preparation, telephone consultations, record requests, appointment no show and cancellation charges. Payment for services is expected at the time of your appointment. If you need to make payment arrangements or questions regarding your medical insurance coverage, please contact our Business Office at 405-341-1697 extension 112 prior to your appointment. Services are offered to you, the client. Responsibility for payment rests with you, not your insurance company. We will not accept responsibility for collecting from your insurance company.

Printed Name of Patient	Signature	Date

USER ELECTRONIC MAIL AUTHORIZATION FORM FOR ELECTRONIC NOTIFICATIONS

Stanbro Healthcare Group utilizes an electronic patient notification system. This system is used to notify your of appointment date/times, appointment reminders, practice alerts (e.g. rescheduled appointments, unscheduled office closure do to severe weather, illness, etc.).

The electronic notifications are sent via text message, email, and automated voice messaging. By signing below, you are giving consent for us to text message, email you, or leave you a voice message regarding your appointments or group related messages. This system will not be used for marketing.

Cell Number including Area Code	Email Address	
Printed Name of Patient	Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Stanbro Healthcare Group Notice of Privacy Practices:

- It tells me how Stanbro Healthcare Group will use my health information for the purpose of my treatment, payment for treatment and Stanbro Healthcare Group health care operations.
- It explains in detail how Stanbro Healthcare Group may use and share my health information for other than treatment, payment and health care operations.
- Why Stanbro Healthcare Group will use and share my health information as required/permitted by law.

Printed Patient Name	Patient Social Security Number	Date of Birth

Signature	Date

HIPAA Document
Retain for six (6) years
Scan to patient chart

STANBRO HEALTHCARE GROUP LLC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. It is the policy of Stanbro Healthcare Group, in accordance with the Oklahoma State Department of Health (OSDH), to keep your medical and personal information confidential. We will only use or disclose your information for the following reasons:

- **Treatment:** We will share your medical information with other medical providers who are involved in your care (including hospitals and clinics), to refer you for treatment, and to coordinate your care with others. We also participate in Electronic Health Information Exchange.
- **Payment:** We may use and disclose PHI when it is needed to receive payment for services provided to you. For example, if you have Medicaid benefits, we will release the minimum information necessary for the Medicaid program to pay us.
- **Health Care Operations:** We will use and disclose PJI when it is needed to make sure we are providing you with good patient care. For instance, we may review your records in order to make certain quality service was given.

Other uses or disclosures of your PHI that may occur include:

- If you have given us permission in writing to release part of your information.
- When ordered to do so by a valid court order.
- When cases of child abuse or neglect are investigated.
- Immunization information is shared with schools and childcare centers.
- When business associates of OSDH, such as community clinics, sign agreements to protect your privacy.
- The SoonerStart Program shares information with the State Department of Education.
- When required by State law.
- We can share your information with anyone as necessary, consistent with Oklahoma law and the OSDH policies and procedures, if we feel there is imminent danger. For example, we will release the minimum information necessary if we believe it will prevent or lessen a serious and imminent threat to the health and safety of a person or the public.
- When services are provided to minors, information will be shared with the Joint Oklahoma Information Network (JOIN). This is done to help us improve the services given to children. However, no one can use your child's information unless you have given permission in writing.
- In the case of a severe disaster we can disclose your information.
- We will share your PHI with other medical providers who are involved in your care to coordinate your care with others.
- We can share your information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for your care, of your location, general condition or death.

Your Rights

You have the right to:

- Receive a list of persons or organizations, other than those listed above, to whom we release your information.
- Request limits on how your information is used or disclosed; however, we are not required to agree to those limits.
- Ask that we not contact you at work.
- Inspect and copy your medical records except in cases involving certain psychotherapy notes.
- Amend incorrect information in your record.
- Revoke your written permission for release of information.
- Receive a paper copy of this Notice of Privacy Practices.

Our Responsibilities

Federal law and the OSDH and its entities require Stanbro Healthcare Group to:

- Maintain the confidentiality of your PHI.
- Provide you with a copy of this notice.
- Abide by the terms of this notice.
- Only change this notice as permitted by Federal law.
- Provide you with a way to file complaints regarding privacy issues.

For additional information regarding this notice and your rights, or to report any complaints regarding privacy issues, contact:

HIPAA Privacy Officer
Community Health Services
Oklahoma State Department of Health
1000 NE 10th Street
OKC, OK 73117-1299
405.271.5585 privacyofficer@health.ok.gov

Secretary of Health and Human Services
The US Department of Health and Human Services
Office of Civil Rights
1301 Young Street, STE 1169
Dallas, TX 75202
214.767.4056 TDD214.767.8940