Penny Chow, M.D., P.A.
Professional Services Agreement

GENERAL INFORMATION:
Phone number: (281) 494-6222, Fax number: (281) 494-6220.
Hours: Monday- Thursday, 8am to 4:30pm.
Friday, 8 am to 12pm.

If you are unable to reach us during business hours, please press 1 to leave a message and we will return your call. Your treatment is strictly confidential. No information regarding your treatment will be released without your written consent. However there are exceptions to confidentiality as required by law, such as information regarding dangerousness to yourself or others and neglect or abuse of a child.

FEES:
Clinical consultations and treatment are on a fee for service basis based on time. Completion of forms or letters would be subject to additional charges. Payment is expected when service is rendered by cash, check, Master Card, Visa, American Express, or Discover. We request a valid credit card number or a deposit to be used in the event of a telephone conference or a missed appointment. Your insurance coverage is independent of my relationship with you. A receipt will be provided for submittal to your insurance carrier. **Initial _____**

CANCELLATIONS:
Twenty-four hour notice is required when canceling an appointment. Monday appointments must be cancelled prior to noon on Friday. Appointments cancelled less than 24 hours or missed appointments are promptly charged to your credit card on file for the full amount of the scheduled time.
Initial _____

PRESCRIPTION REFILLS:
For medication refills, call your pharmacy several days before running out of medications. For mail orders or stimulants, call our office. We require 24 hours notice in order to process these requests as they may require faxes, long distance phone calls, or legal documentation. If you have missed a scheduled appointment and need a medication refill, you will only be given enough medications until your next scheduled appointment. If your appointment is not rescheduled or you do not keep your appointment, you may experience medication withdrawal, requiring treatment in the emergency room.
Initial _____

AFTER HOURS:
If you have an EMERGENCY, go to the nearest ER or call 911. If there is an urgent matter, you can leave a message on my after-hours voicemail and I will get back with you as soon as possible. You may be subject to a service charge. **Initial _____**

ACKNOWLEDGEMENT:

I have carefully read the information above and accept the Professional Services Agreement.

Signature: _____ Date: _____

I have also been given the opportunity to read and possess a copy of this office's Privacy Practices.

Signature: _____ Date: _____

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PENNY CHOW, M.D, P. A.
52 Sugar Creek Center Blvd., Ste 225
SUGAR LAND, TX 77478

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: We are required by federal and state law to maintain the privacy of your health information. We are also Required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician, or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operations: We may use and disclose your health information in connection with our Healthcare operations. These include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the patient rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information

that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies or other forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing.

Required by law: We may use or disclose your health information when we are required by law to do so.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request a copy in a format other than photocopies. We will use the format you requested unless we cannot practicably do so. You must request in writing to obtain access to your health information. You will be charged a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, we will charge you $20 for the first 20 pages and then $0.50 per page after that and postage if you wish the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Contact us for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operation and certain other activities beginning April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing, and must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be made in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice by electronic mail, you are entitled to receive this Notice in written form.

Questions and complaints: If you have questions or wish more information about our privacy practices, please contact us. If you are concerned that we may have violated your privacy rights or disagree with a decision we made about access to your health information, or in a response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us using information listed at the end of this notice. You may also complain to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us, or the U.S. Department of Health and Human Services.

Dr. Penny Chow
52 Sugar Creek Center Blvd. Ste. 225
Sugar Land, TX 77478
(281)- 494-6222

Penny Chow M.D.

Clinical Information

Personal Information

Name:	
Occupation:	
Spouse's Name:	Spouse's Occupation:

Developmental Information

Birth Place:			Number of Siblings:
Have you ever been a victim of abuse: Yes/ No			
If so, what type(s) (Physical, Sexual, Emotional):			
History of Arrests or Convictions: Yes / No			Are you a smoker: Yes / No
History of Drug Use (Circle all that apply):	Barbiturates/Sedatives		Cocaine/Crack
Marijuana	Heroin/Opiates		Amphetamine/Speed
PCP	LCD/Hallucinogens		
Alcohol Consumption per week (# of drinks):			
Education: Not Graduated High School	High School or GED	Some College	2 Yr College
4 Yr College	Masters	Professional School/PHD	
Number of jobs as an adult:		Number of Marriages:	
Number of Children:		Religion:	

Medical Information

Primary Care Physician:
Reason for seeing a Psychiatrist:
Name of Previous Psychiatrist or Therapist (if any):
Previous Psychiatric Hospitalizations (when):
Current Medication/Supplement(list all):
Medication Allergies (List all):

Medical History (Circle):

Diabetes	Thyroid Problems	HIV/AIDS	Cancer
Liver Disease	Lung Problems	Seizures/Epilepsy	Kidney Disease
Heart Disease	High Blood Pressure	Gastrointestinal Disease	Stroke

Other: _____

Psychiatric History: Circle "S" for self and "F" for family.

Depression	S	F	Bipolar Disorder	S	F	Alcohol Abuse	S	F
Anxiety Disorder	S	F	OCD	S	F	Attempted Suicide	S	F
Schizophrenia	S	F	Drug Abuse	S	F	Completed Suicide		F

Other: _____

Please circle all symptoms that apply:

Depressed Mood	Overly Confident	Anxious	Tense
Insomnia	Racing Thoughts	Feeling Paranoid	Restless
Excessive Sleep	Impulsive Spending	Forgetful	Worrying Needlessly
Increased Appetite	Increased Productivity	Distractible	Repetitive Thoughts
Decreased Appetite	Hearing Voices	Disorganized	Compulsive Behaviors
Low/High Energy	Suicidal Thoughts	Startle Easily	Frequent Nightmares
Loss of Pleasure	Anger/Irritability	Heartracing/Pounding	

Past Medication History (Circle all you have currently or previously taken)

Antidepressants: (Circle)

Prozac/Sarafem (Fluoxetine)	Zoloft (Sertraline)	Lexapro (Escitalopram)
Celexa (Citalopram)	Cymbalta (Duloxetine)	Fetzima (Levomilnaciprin)
Luvox (Fluvoxamine)	Elavil (Amitriptyline)	Pamelor (Nortriptyline)
Tofranil (Imipramine)	Sinequan (Doxepin)	Norpramin (Desipramine)
Desyrel (Trazodone)	Serzone (Nefazdone)	Nardil (Phenelzine)
Marplan (Isocarboxazid)	Emsam (Selegiline)	Parnate (Tranylcypromine)

Antidepressants (cont.):

Remeron (Mirtazapine)	Trintellix (Vortioxetine)	Pristiq (Desvenlafaxine)
Effexor XR (Venlafaxine)	Wellbutrin SR/XL, Zyban, Aplenzin (Bupropion)	
Viibryd (Vilazodone)	Paxil/Pexeva/Brisdelle (Paroxetine)	

Anti-Manic/Mood Stablizers: (Circle)

Haldol (Haloperidol)	Prolixin (Fluphenazine)	Risperdal (Risperidone)
Keppra (Levetiracetam)	Zyprexa (Olanzapine)	Vraylar (Cariprazine)
Seroquel (Quetiapine)	Geodon (Ziprasidone)	Clozaril (Clozapine)
Abilify (Aripiprazole)	Saphris (Asenapine)	Latuda (Lurasidone)
Fanapt (Iloperidone)	Gabitril (Tiagabine)	Topamax (Topiramate)
Depakote/ER (Valproic Acid)	Symbyax (Fluoxetine/Olanzapine)	Lamictal/CR (Lamotrigine)
Neurontin (Gabapentin)	Invega/ Sustenna/Trinza (Paliperidone)	Lyrica (Pregabalin)
Lithium Carbonate/Eskalith/ CR (Lithium)		
Carbatrol/Tegretol/XR/ Equetro (Carbamazepine)		

Anti-Anxiety/Sedative/Hypnotics: (Circle)

Cogentin (Benztropine)	Atarax (Benztropine)	Buspar (Buspirone)
Klonopin (Clonazepam)	Ativan (Lorazepam)	Xanax XR (Alprazolam)
Valium (Diazepam)	Sonata (Zaleplon)	Ambien/CR (Zolpidem)
Lunesta (Eszopiclone)	Rozerem (Ramelton)	Silenor (Doxepin)
Belsomra (Suvorexant)		

Stimulants/ADHD Medications: (Circle)

Adderall/XR (Amphetamine)	Dexedrine (Dextroamphetamine)	Concerta (Methylphenidate)
Cylert (Pemoline)	Strattera (Atomoxetine)	Provigil (Modafinil)
Vyvanse (Lisdexamfetamine)	Evekeo (Amphetamine Sulfate)	Nuvigil (Armodafinil)
Focalin XR (Dexmethylphenidate)	Ritalin SR/L (Methylphenidate hydrochloride)	

Additional Comments:

Penny Chow, M.D., P.A.
52 Sugar Creek Center Blvd. Ste 225
Sugar Land, TX 77478
Tel: (281) 494-6222 Fax: (281) 494-6220

Consent for Evaluation and Treatment

Name of Patient: _____ Date: _____

Name of Parent or Guardian: _____
(Patient is a minor or under guardianship)

I voluntarily consent to and authorized Dr. Penny Chow to perform evaluation and treatment for the purposes of my medical care. I understand this may include diagnostic testing, psychological testing, psychotherapy, medication management, and other appropriate alternative treatments.

I understand the non-compliance to medication could result in withdrawal symptoms that may require treatment in the emergency room.

I understand psychiatric medications could be prescribed off label for treatment of my condition as standard of practice in the community. I will be informed of such practices and given opportunity to ask questions and participate in my care.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian Date

_____ _____
Signature of Witness Date