J. Bernard Cordoba, M.D.
1101 S Capital of Texas Hwy Bldg A, Suite 250
Austin, TX 78746
(Phone) 512.451.4448 (Fax) 512.451.9066

Consent for Treatment

I give my full consent for the completion of an evaluation, evaluative procedures and the provision of treatment as necessary in Dr. Cordoba's judgment until I otherwise notify J. Bernard Cordoba, M.D.

_____

Signature Date

Confidentiality Policy

Your contacts with J. Bernard Cordoba, M.D. are confidential. Information discussed may not be released without your permission except as indicated below:

Exceptions to absolute confidentiality:

1. Your contacts reveal a danger to self or others
2. Child or elder/dependent abuse is suspected

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GENERAL OFFICE POLICIES

1. Dr. Cordoba is not a network provider for any insurance company or Medicare. Payment in full is due at the time services are rendered.

2. PPO Participants are responsible for obtaining necessary referrals prior to appointment. Laboratory tests are billed to your insurance company by the reference lab. You may receive a separate bill from the laboratory for any deductible or non covered service. Should your insurance carrier require you to use a specific ancillary laboratory, please inform your physician. Failure to do so may results in charges to you which your insurance company may not cover.

3. You will be responsible for payment in full if you miss your appointment or fail to cancel with less than 48 business hour notice. Missed appointment fees must be paid prior to the next appointment.

4. Any financial concerns should be discussed with Dr. Cordoba 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.

5. For medication refills, please contact your pharmacy unless you need a "triplicate prescription". We require 72 business hour notice for all refill requests.

6. The fee for a "triplicate prescription" is $17. A 72 business hour notice is required. These prescriptions must be either picked up at the office or mailed directly to the patient.

7. Allow 3 business days for controlled substance refills. Once written and mailed via US Postal Service, I have no control as far as when these are delivered to the requested address.

8. By law, all triplicate prescriptions must be filled within 21 days of the date written. There will be an $20.00 charge for all triplicates that need to be re-written.

9. Time spent in processing your clinical information with case managers and/or other providers will be billed on a fee for service basis that may not be covered by your insurance plan. Similarly, you will be billed for all necessary correspondence such as letters, reports or required forms. Such information may only be released upon your written request.

10. Office hours are by appointment only. Phone calls lasting longer than five minutes will be charged at the regular rate.

11. Dr. Cordoba reserves the right to terminate the professional relationship with any patient at any time for failure to comply with treatment recommendations, office policies, and/or failure to meet his or her financial obligations. Specific details apply in these circumstances and will be discussed in detail.

12. Patients are under no obligation to continue services should they decide to terminate at any time. You may discontinue treatment in person, by phone or in writing. A written termination statement is ultimately required.

13. If you have an urgent matter that cannot wait for 24 hours, you may contact Dr. Cordoba via the urgent care line at 512.750.3265. This line should ONLY be used in urgent situations. I will not respond to text messages nor e-mail. Messages left on this line that are not clinically defined as urgent will be answered as a routine call. If you have a life threatening emergency call 911 immediately.

14. Please be aware that obtaining Prior Authorizations for medications from your insurance company takes a considerable amount of time and may require several phone calls to receive an answer. Allow at least 7 business days for this to be completed.

15. The process of filling out forms as well as processing requests for various reasons (insurance, disability, job related etc.) also is a time demanding process. This also may require various revisions and attempts to communicate with the respective entity. Allow at least 7 business days for this to be completed.

16. Please notify Dr. Cordoba of any changes in your medical/surgical condition and medication additions/deletions from any medical providers at all times. This includes over the counter agents, supplements, herbs and "alternative medicinal" agents.

A copy of GENERAL OFFICE POLICIES will be provided to you upon request. You may also review the policies at www.cordobamd.com

_____ _____

Printed Name In agreement, Signature/Date

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(SCL-90 ADULT HEALTH HISTORY)

Patient Name_____ Date_____

Sex: M F Date of Birth_____ Yrs. Of Eduation_____

1) Please Describe the reason(s) you are seeking treatment:

_____

_____

_____

2) When did the problem being and what motive you to seek treatment now?

_____

_____

3) On the scale below, please estimate the current severity of the problem(s):

_____	_____	_____	_____
mildly upsetting	moderately severe	very severe	totally incapacitating

4) List all past or present mental health treatments:

Dates	Type of Treatment	Doctor/Therapist's Name	Where

5) List all current medications including herbs, supplements and over the counter agents

_____

_____

6) List all medications taken in the past for emotional and psychiatric reasons and dates taken:

_____

_____

7) Are you allergic to any medication? (if yes, please list)

_____

8) Mark and (x) for any of the following that have ever applied to you:

Medical	Mental Health
____ asthma	____ juvenile delinquency
____ glaucoma	____ school phobia
____ liver disease	____ family problems
____ kidney disease	____ teenage pregnancy
____ pancreatitis	____ bedwetting
____ monomucleosis	____ sexual abuse
____ epilepsy	____ anorexia
____ thyroid disease	____ binge eating
____ cancer	____ behavior problems
____ heart trouble	____ sexual problems
____ diabetes	____ sexual identity issues
____ venereal disease	____ sexually transmitted diseases
____ AIDS or HIV+	____ childhood fears
____ chronic pain	____ hyperactivity
____ high blood pressure	____ running away
____ chronic pain	____ truancy
____ sleep disorder	____ physical abuse
____ high blood pressue	____ incest
____ head injury	____ rape

Other not mentioned above:_____

9) Please list any past or current medical problems or mental illnesses (depression, anxiety, chemical dependency, psychiatric hospitalizations etc.) Incurred by any of your blood related relatives:

_____

_____

10) List any specific requests or special needs that you require:

_____

_____ _____ _____

Patient Name Signature Date

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WHAT TO EXPECT FROM OUR RELATIONSHIP

I will use my psychiatric knowledge, training, experience and skills to the best of my ability to help you. I follow the rules, standards and ethical principles of the APA. Federal and state laws a well as the APA rules require that I keep information about you private and confidential. I will not give information about you to anyone without your written permission and consent (except in certain limited situations as explained in the "Notice of Privacy Practices" section). I can only be your Psychiatrist and can have no other role in your life. I cannot have a business relationship with you.

NOTICE OF PRIVACY PRACTICES

I will treat all of the information you share with me with great care and confidentiality. The confidentiality and privacy of your meetings and my records about you are protected by federal and state law as well as by the rules of my profession. In general, I will tell no one what you tell me or reveal that you are using my service. Exceptions to this are:

1. Your contacts reveal a danger to self or others. This is required to try to protect you and/or the other person/s.
2. Child or elder abuse is suspected

In the event that you are being sued, suing someone or are charged with a crime, I may be court ordered to reveal your information. Please consult with an attorney about these issues. If you use medical insurance to cover the cost of my services, they may require some or all of your records. That information may become part of your permanent medical record. Once released, I no longer have any control over what happens to it or how it may be used.

In the event that your case requires supervision with a qualified peer, I will ask you permission to present your clinical case without divulging your identity. Except for the situations described above, I will always maintain your privacy. I also ask that you do not disclose the name/identity of any other patient being seen in this office. You may review your records, but I am not allowed to share records that have been sent to me by another provider/organization unless there is a written consent from that other person/organization.

J. Bernard Cordoba, M.D.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of J. Bernard Cordoba M.D.'s "Notice of Privacy Practices". I understand that if I have any questions regarding the "Notice" of my privacy right I can contact Dr. Cordoba's office at 512-451-4448

_____ _____

Signature Date

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BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

PLEASE FEEL FREE TO DISCUSS ANY CHARGE OR OFFICE POLICIES WITH ME.

Name_____ Date_____ Sex M F

Home Phone_____ Cell Phone_____

Address_____

City_____ State_____ Zip Code_____

Marital Status_____

Person Responsible for Payment_____Relationship _____

Address_____

_____
City State Zip Code

Patient Occupation_____ Employer_____ Phone_____

Spouse Name_____Phone_____

Okay to leave a confidential message?_____

Emergency Contact_____Phone_____Work_____

Referring Physician/Other_____

_____Above information is new

_____Name has been changed, previous name_____

Signature_____