HEALTH
TELEBEHAVIORAL CARE

Telebehavioral Care Program
Phone: (979) 436-0700 Fax: (979) 436-0062
health.tamu.edu/telehealth

Client Information and Frequently Asked Questions

Description of Services

The TBC is a non-profit psychological service and training clinic operated under Texas A&M Health. The TBC also operates under the administration of the Department of Educational Psychology and the Department of Psychiatry at Texas A&M Health. Psychological services are provided by a team consisting of graduate students who are sufficiently advanced in their clinical training in the specialties of counseling, clinical and school psychology. All counselors are supervised by a licensed professional. The TBC is open Monday through Friday from 8am-5pm, but each remote site clinic may have different hours. The services provided by the TBC are primarily "telehealth" services, which literally means "health at a distance." Most services are conducted using secure, confidential videoconferencing equipment at the local health site while other sessions may potentially be conducted using your personal devices for in-home video or phone sessions. In-home video or phone sessions are not guaranteed and client appropriateness for these modalities is determined by the counselor and their supervisor. You are responsible for any fees associated with other clinics you may visit under the Texas A&M Health system. Counseling services at the TBC in the eligible counties are free.

What is counseling?

Counseling is not easily described in general statements but commonly involves looking at and addressing patterns that may be causing problems. It varies depending on the personalities of the counselor and client, and the particular problems you bring forward. There are many different methods that can be used with the problems that you hope to address. Counseling is not like a medical doctor visit. Instead, **it calls for a very active effort on your part**. In order for counseling to be most successful, you will have to work on things we talk about both during our sessions and at home. Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

What can I expect at the TBC?

The first session is an intake session which is primarily focused on information sharing and gathering. A preliminary plan may be formed by the end of the intake session with further evaluation of your needs and goal setting often occurring for a couple more sessions. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan to follow, if you decide to continue with counseling. We reserve the right to terminate treatment and refer you to other services at any point during your time with the TBC. This is due to the TBC being a training clinic, and we are required to work within our ethical and professional competencies. If proceeding with counseling, you will typically meet once per week for a 45-minute session at a mutually agreed upon time.

What happens if the technology isn't working?

If your video session disconnects, please wait for your counselor to try and reconnect. The counselor will attempt to troubleshoot any issues and complete the session via video. If the connection cannot be resumed, you and the counselor can decide whether to conduct the session over the phone. Additionally, the video-

platform used provides 24/7 support that you can access if there are problems on your end. To access, click the “HELP” icon to start the chat or call 800-490-2788. If you are having a phone session and the call gets disconnected, your phone runs out of minutes, etc., please call the clinic back from a working phone to finish your session or call back within 24 hours to reschedule your session.

Since it’s telehealth, can I conduct my session anywhere?

If your session is not at the remote clinic site, it is expected that you will conduct any in-home video and phone sessions from a safe, confidential location within our service area of the Brazos Valley. We are not familiar with emergency or referral resources outside of our service area and would not be able to adequately take care of you in case of an emergency if you travel outside our region. Additionally, supervisor licenses do not extend outside of the state of Texas. You should not conduct your in-home video or phone session while driving, in a place where you can be distracted, or where your confidentiality might be in question such as the grocery store or the car repair shop.

Session Limit

Each client is held to a 20 session limit within each calendar year. You may access other services within Texas A&M Health according to their policies.

Weekly Assessments

The TBC uses routine assessment tools that you will complete before each session. The assessment will be sent to your email and you will complete them online. First and foremost, these assessments are used much like a thermometer is used at your doctor’s office. Your counselor can get an “emotional thermometer” reading on your symptoms and distress levels. Please ask your counselor for more information about your assessment results at any time. Our weekly assessments are also used to report back to our funding sources to prove that our services are valuable and effective. But don’t worry, we always de-identify the data from these weekly assessments so that the responses can’t be traced back to you in any way.

Contacting Your Counselor

Your counselor will usually not be immediately available by telephone. Although we will be using e-mail for log in purposes and some other reminders or announcements through the telehealth program, e-mail and social media are not secure methods of communication. It is the policy of the TBC not to allow communication between counselors and clients via e-mail or any social media application. The TBC will also be closed during university breaks and holidays. When the TBC is open, you can leave a message with a TBC staff member who will contact your counselor. When the TBC is closed, please leave a message on the answering machine. Be aware that it may be several days before your counselor will be able to call you back. Please inform your counselor of some times when you will be available. If it is an emergency, please refer to the emergency procedures below.

Emergency Procedures

The TBC, as a training facility, operates on the Texas A&M university. schedule. During those times when the TBC is not open, the answering machine will allow you to leave a message. Night, weekend, and holiday emergency assistance is available through calling 911 or calling one of the following:

MHMR 24-Hour Crisis Hotline 1-888-522-8262 ● Brazos County Sheriff 979-361-4900

St. Joseph Regional Health Center 979-776-3777

Grievance Procedure

If at any time you are dissatisfied with the services that you are receiving through the TBC, please notify Dr. Carly McCord, TBC Director of Clinical Services. In addition, anyone who believes that a licensed professional has violated either the Psychologist’s Licensing Act (state law) or the rules of the Board may file a complaint with the Texas State Board of Examiners of Psychologists.

HEALTH

Family Care, Bryan	Behavioral Health	Family Care, Navasota	Psychiatry	Telebehavioral Care
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Office Hours

Family Care, Bryan
Monday & Thursday
8AM – 7PM

Tuesday, Wednesday, and Friday
8AM – 5PM

Behavioral Health, Bryan
Monday & Thursday
8AM – 7PM

Tuesday, Wednesday, and Friday
8AM – 5PM

Family Care, Navasota
Monday-Thursday
8AM – 5PM

Friday
8AM – 12PM

Psychiatry
Monday-Friday
8AM – 5PM

Telebehavioral Care
Monday-Friday
8AM – 5PM

After Hour Care: There is always a doctor on call. The doctor will do their best to help you, but an exam may be needed in order to provide better care. The doctor may need to ask that you go to another location such as an emergency room so that immediate care can be provided.

Arriving for Your Appointment:
Please bring Past Medical Records and/or Vaccination Records, all current medications within their original bottles, Insurance Card, and Photo ID to every appointment.

Patient should arrive **10-15 *minutes* <u>before</u> your scheduled appointment**. New patients should arrive at least ***30 minutes* <u>before</u> your scheduled appointment** to ensure all new patient information is complete prior to your scheduled appointment time.

Treatment of Minors:
Patients under the age of 18 must be with a parent or legal guardian OR have written permission for treatment from a parent or legal guardian if accompanied by another adult. For in-person appointments, an adult must stay with the minor at all times. If the minor is left unattended, treatment will not move forward and the appointment may be cancelled.

Cell Phone Usage:
In order to provide the best care possible, we request no cell phone usage during patient visits. It is in the interest of your safety that you provide your full attention to your care team and be an active participant in your treatment plan.

Prescriptions and Refills:
The best time to get a prescription refill is at your appointment. If you need a refill, please contact your pharmacy and ***allow 72 hours for processing***. DO NOT wait until you have run out of medication. Some medications have side effects that need to be watched. We require check-up appointments every 3-4 months for these medications. Be sure to keep these follow-up appointments. Some prescriptions CANNOT be called in; these prescriptions must be written for you to pick up and ***will be processed within 72 hours.*** You are required to bring a photo ID each time you pick up these prescriptions.

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Controlled Substances:

We DO NOT call in controlled substances after hours. Controlled substances may be prescribed by our doctors, but only after reviewing your records. The medications will be ***processed within 72 hours***, if prescribed. If you require chronic use of controlled substances, our physicians may refer you to a special doctor. You may also be asked to agree to a controlled substances/pain medicine contract and/or agree to submit to urine drug screens.

Dismissal from Texas A&M Health:

If you are dismissed from our practice, you can no longer schedule appointments, get medication refills, or receive care from any Texas A&M Health providers. Please understand we may dismiss you as a patient for any of the following actions:

- Do not come for schedule appointments.
- Do not follow the provider's instructions for your treatment plan.
- You incorrectly use controlled substances, including ADHD medications.
- You or a family member uses improper or abusive language with our providers and/or staff OR show violent or threatening behavior that puts our providers, staff, and/or other patients and visitors at risk.

Please sign and date that you have read and understand our office policy.

Thank you.

_____ _____

Name of Patient (Please Print) *Date*

_____ _____

Signature of Patient or Legal Guardian *Relationship to Patient*

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Patient Name: _____ **DOB:** _____

Definition of a "No-Show" Appointment

Texas A&M Health defines a "No-Show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Cancels within less than 24 hours' notice
- Arrives more than 10 minutes late and is consequently unable to be seen

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-show" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot

How to Avoid Getting a "No-Show"

1. Confirm your appointment
2. Arrive 10-15 minutes early
3. Give at least 24 hours' notice to cancel appointment

1. **Appointment Confirmation**: Texas A&M Health will attempt to contact you 1-2 days before your scheduled appointment to confirm your visit. Please make sure you confirm your appointment through this call.

2. **Always Arrive 10-15 minutes Early**: When you schedule an office visit with us, we expect you to arrive in our practice 10-15 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and paperwork, if needed, before the scheduled visit.

3. **Give 24 hours' Notice if you need to Cancel**: When you need to cancel or rescheduled your visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient.

Consequences of "No-Show" Appointments

If you miss 3 consecutive OR 4 total appointments within a 12-month period you may be dismissed from the clinic.

I have read and understood the Texas A&M Health Clinic's "No-Show" Policy as described above.

_____ _____

Patient or Legal Guardian Signature Date

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PATIENT INFORMATION

First Name: _____ Middle Initial:_____ Last:_____

Previous Name, if applicable: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____

Work: (_____) _____-_____ Ext. _____

Email: _____@_____._____

Date of Birth: __ __ / __ __ / __ __ __ __ Sex: ☐ Male ☐ Female ☐ Unknown

Social Security Number: __ __ __ __ - __ __ - __ __ __ __

Referring Provider: _____ Preferred Pharmacy: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Legally Separated

Language: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White
☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

If Minor or Student:

Mother's Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

Father's Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

Guardian's Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Relationship to patient: _____ Social Security Number: __ __ __ __ - __ __ - __ __ __ __

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____

Work: (_____) _____-_____ Ext. _____

Emergency Contact (not self/parent):

Name: _____ Relationship: _____

Address: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____

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Patient Name: _____ DOB: _____

ACKNOWLEDGEMENT AND CONSENT OF RECEIPT OF NOTICE OF PRIVACY

I have reviewed Texas A&M Health Science Center's Notice of Privacy. This policy explains how my medical information will be used and made known. I can get a copy of this document at no cost to me if I ask for it.

Patient requested copy: ☐ Yes ☐ No

CONSENT FOR PRESCRIPTION RECONCILIATION

I, _____, will let my doctor and/or his staff to look at my bills from my pharmacy to see what medications I have purchased.

CONSENT TO RELEASE MEDICAL INFORMATION TO PERSONAL REPRESENTATIVE

I, _____, hereby consent to have my information released to the following individuals. This consent will remain in effect until otherwise notified by me in writing.

☐ Appointment times
☐ Billing/Demographic Information
☐ Medical Information
☐ Do NOT release any information, except to healthcare providers

Name	Relationship
_____	_____
_____	_____
_____	_____

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Patient Name: _____ DOB: _____

CONSENT AGREEMENT FOR TELECOMMUNICATIONS/EMAILS

I authorize Texas A&M Health to send text messages and/or emails regarding appointment reminders to me/representatives on the provided cell phone number and/or email. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my cell phone provider may apply.

(_____)_____-_____
Patient's/Guardian's Cell Phone

_____@_____._____
Patient's/Guardian's Email

(_____)_____-_____
Authorized Individual's Cell Phone

_____@_____._____
Authorized Individual's Email

_____ _____
Authorized Individual *Relationship*

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text message services. I understand that this authorization can only be revoked in writing. *It is important to know that text communication is not always secure. Text messages can be intercepted and for this reason, we do not communicate personal health information through this method.*

_____ _____
Name of Patient (Please Print) *Date*

_____ _____
Signature of Patient or Legal Guardian *Relationship to Patient*

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Patient Name: _____ DOB: _____

MEDICAL TREATMENT CONSENT AND FINANCIAL AGREEMENT

I, _____, (if minor, for _____) hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by Texas A&M Health or their authorized designees, as they may in their professional judgment be necessary to prove appropriate medical care.

All Medical Fees are due at the time of your appointment, unless other arrangements have been approved.

- Services are rendered to the patient, not the insurance company. Our office will file your insurance if proper information is received.
  - You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance.
  - For unpaid claims over 45 days, it is your responsibility to follow up with your insurance company and the balance may be considered due and payable.
- It is your responsibility to notify the office of any changes in your insurance or demographics.
- You will be responsible for any charges that occur if changes to your current insurance are not communicated at the time of service.
- Expenses occurred to collect patient-responsible debt may be charged to the patient or guarantor.

By signing,

- I authorize Texas A&M Health to submit bills to my insurance company for services provided by my medical providers.
- I authorize the release of information of the patient's necessary medical information in order to process claims associated with medical care.
- I authorize payment to be made to Texas A&M Health for Services provided by them.
- I have received and/or accept to the following agreements and/or policies:
  - **Notice of Privacy**
  - **No Show Policy Acknowledgement**
  - **Consent for Prescription Reconciliation**
  - **Consent to Release Medical Information to Personal Representative**
  - **Consent Agreement for Telecommunications/emails**
  - **Medical Treatment Consent and Financial Agreement**

_____ _____

Signature of Patient or Legal Guardian *Relationship to Patient*

_____

Date

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Audio/Video Recording Authorization Form

I understand that audio/video recording may occur during my clinic visits for supervision and teaching purposes:

- I understand that the medical trainees and counselor trainees are supervised by a licensed psychologist and/or licensed physician during all audio/video recorded clinic visits.
- I understand that medical staff and medical trainees may view my appointment through the use of audio/visual recording for the purpose of clinical supervision and teaching.
- I understand that audio/video recordings of my clinic visits are used only for the purpose of clinical supervision and teaching.
- I understand that audio/video records of my clinic visits will comply with all HIPAA regulations, and will be stored on a password protected computer.
- I understand these recordings are not part of my medical record and will be deleted annually on June 30th.

☐ **I have read (or heard a staff member read to me if unable to read), understand, and AGREE to the procedures outlined for audio/visual recording.**

☐ **I have read (or heard a staff member read to me if unable to read), understand, and DO NOT AGREE to the procedures outlined for audio/visual recording**

_____ _____

Name of Patient (Please Print) *Date*

_____ _____

Signature of Patient or Legal Guardian *Relationship to Patient*

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
"NOTICE OF PRIVACY PRACTICES"

Effective Date: April 14, 2003; revised September 17, 2013

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.

If you have any questions about this Notice, our policies or clinic locations, please contact the Texas A&M Health Science Center Privacy Officer at: 200 Technology Way, College Station, Texas 77845, (979) 436-9248.

Who We Are

This Notice describes the privacy practices of the Texas A&M Health Science Center (TAMHSC) and services furnished by its Health Care Providers (College of Medicine and College of Dentistry) Federal law requires us to provide this Notice to you.

Who Will Follow This Notice?

This Notice describes our TAMHSC's Health Care Providers and those of:

- Health care professionals who are members of our workforce authorized to access and/or enter information into your medical record or billing record;
- All departments and units of our clinic locations;
- All employees, volunteers and other clinic location personnel considered a part of our workforce; and,
- Any health care entities and medical offices owned by or affiliated with our Health Care Providers.

Our Pledge Regarding Medical and Billing Information

We understand that information about you and your health is personal. We are committed to protecting medical and billing information about you. We create a record of the care and services you receive from our Health Care Providers. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, a plan for future care or treatment, and charges or bills for services related to your care. These records are used to provide you with quality care and to comply with certain legal requirements.

This Notice applies to all of the records of your care generated by our Health Care Providers. You may have a different Notice presented to you, if your care is provided in an affiliated facility.

This Notice will tell you about the ways in which we may use and disclose medical and billing information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Make sure that medical and billing information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy clinic locations with respect to medical and billing information about you; and
- Follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Medical and Billing Information About You

The following categories describe different ways we use and disclose medical and billing information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Electronic Disclosure

Your protected health information is subject to electronic disclosure. If we disclose your protected health information electronically for any reason other than for treatment, payment, health care operations, or as otherwise authorized or required by law, we cannot do so without your authorization for each disclosure.

At your request, we are authorized to send protected health information to you via email. However, there are significant risks associated with utilizing unencrypted emails.

For Treatment

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff, or other medical personnel who are involved in taking care of you by our Health Care Providers.

We may also disclose information about you to other health care providers outside our clinic location so they may treat you. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. He may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions, scheduling lab work, and ordering x-rays. We may also disclose medical information about you to family members and other health care professionals outside our clinic location who may be involved in your medical care. This information is shared on the basis of other health care staff "needing to know" the information about you to provide safe necessary treatment to you.

For Payment
We may use and disclose medical information about you so the treatment and services you receive at our clinic location may be billed to and payment may be collected from you, an insurance company, or other third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

We may also use or disclose your health information to our billing department/company or consumer reporting agencies for claims management or collection activities pertaining to the collection of payments owed to us.

For Health Care Operations
We may use and disclose medical information about you for office operation. These uses and disclosures are necessary for patient quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who you or other patients are as individuals. We may provide information about you to other health care providers, health plans, or health care clearinghouses to perform activities such as quality assessment, case management, training, and studying groups of people for the purpose of improving health.

Appointment Reminders
We may use and disclose medical information to contact you as a reminder that you have an appointment for tests, treatment or medical care.

Treatment Alternatives
We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you or offer you optional care alternatives.

Health-Related Products and Services
We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care
Unless you tell us otherwise, we may release medical information about you to a friend or family member who is involved in your medical care. We may give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are at our clinic location. In addition, we may disclose medical information about you to an entity assisting us in a disaster relief effort so that your family can be notified about your condition, status, and location.

Business Associates
There are some services provided in our organization through contracts with business associates. Examples may include transcription services, billing services or healthcare clearinghouse. When these services are contracted, we may disclose your health information to our business associates so they can perform the jobs we've asked them to do and bill you or your third-party payer for services rendered. All of our business associates, including contractors and sub-contractors that receive or have access to protected health information, are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Research
Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of patients who received one medication to those who received another, for the same condition. Before we use or disclose medical information for research, the project will go through a special approval process. In certain circumstances, we are permitted to disclose medical information about you to people preparing for research. For example, researchers may look for patients with specific treatment needs to develop a research protocol, but may not remove the medical information they review from the clinic location.

As Required by Law
We will disclose medical information about you when required to do so by federal, state, or local laws.

To Avert a Serious Threat to Health or Safety
We may use or disclose medical information about you when necessary to prevent a serious threat to you health and safety or the health and safety of the public or other person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation
If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military Personnel
If you are a member of the armed forces, active or reserve, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation
We may release medical information about you as necessary to comply with laws related to worker's compensation or similar programs that provide benefits for work-related injuries or illnesses.

Public Health Risks
We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease, or who may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government or law enforcement authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime, if under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the clinic location; and

- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about you as a patient of our Health Care Providers to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others
We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons and foreign heads of state or to conduct special investigations.

Inmates
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Uses of Medical Information: Authorization and Right to Revoke Authorization
The following uses and disclosures of your protected health information will be made only with your written authorization:

1. Uses and disclosures of protected health information for marketing purposes;
2. Disclosures that constitute a sale of your protected health information; and
3. Disclosure of psychotherapy notices, except for certain treatment, payment or health care operations activities.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you authorize us to disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required by state law to retain our records of the care that we provide to you.

Childhood Immunizations
We may disclose immunization records to schools who are required to obtain proof of immunization prior to admitting the student as long as we have the patient or patient's legal representative's consent to the disclosure.

Genetic Information
Your genetic information is considered protected health information and to the extent we are deemed to be a health plan we are prohibited from using or disclosing genetic information for underwriting purposes.

Your Right Regarding Medical and Billing Information About You

You have the following rights regarding your medical and billing information we maintain.

Right to Notice of Breach
You have the right to be notified if we or one of our business associates become aware of a breach of your unsecured protected health information. A breach means the acquisition, access, use, or disclosure of your unsecured protected health information in a manner not permitted under the law that compromises the security or privacy of your protected health information.

Right to Restrict Disclosure for Services Paid by You in Full
You have the right to restrict the disclosure of your protected health information to a health plan if the protected health information pertains to health care services for which you paid in full directly to us.

Right to Inspect and Copy Your Medical and Billing Information
You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does **not** include psychotherapy notes. To inspect and obtain a copy of medical and billing information that may be used to make decisions about you, you must submit your request in writing to the TAMHSC Privacy Officer, 200 Technology

Way, College Station, Texas, 77845. If you request a copy of the information, we must respond to you within fifteen (15) business days and may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy this information in certain limited circumstances. If you are denied access to medical or billing information, you may make a request, in writing to the TAMHSC Privacy Officer, 200 Technology Way, College Station, Texas, 77845 that the denial be reviewed. Another licensed health care professional chosen by the clinic location will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend Your Medical and Billing Information
If you feel that medical and billing information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept by or for the facility. To request an amendment, your request must be made in writing and submitted to the TAMHSC Privacy Officer, 200 Technology Way, College Station, Texas, 77845. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical or billing information kept by or for the clinic location;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures of Your Medical and Billing Information
You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical and billing information about you, except for those disclosures to carry out treatment, payment or health care operations, disclosures made to you, disclosures you have authorized or certain other disclosures. To request an accounting of disclosures, you must submit your request in writing to the TAMHSC Privacy Officer, 200 Technology Way, College Station, Texas, 77845. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on the uses and disclosures of your medical or billing information for treatment, payment or health care operations. You also have the right to request a restriction on the medical or billing information we disclose about you to someone who is involved in your care or payment for your care, like a family member or friend. For example, you could ask that we **not** use or disclose information about your particular surgery or other particular treatment. **We are not required to agree to your request.** If we cannot agree to your requested restriction, we will notify you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We may terminate our agreement for a restriction if we inform you and you agree. To request restrictions, you must make your request in writing to the Privacy Officer, 200 Technology Way, College Station, Texas, 77845.

Right to Request Confidential Communications
You have a right to request that we communicate with you about medical treatment and options in a certain way or at a certain location. For example, you can ask that we contact you at a different phone number or address than that shown in your records. To request confidential communications, you must make your request in writing to the TAMHSC Privacy Officer, 200 Technology Way, College Station, Texas, 77845. We will **not** ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this Notice. You will be offered a paper copy during the admission or registration process. You may ask the Health Care Provider to give you a copy of this Notice at any time, or you may contact the TAMHSC Privacy Officer, 200 Technology Way, College Station, Texas, 77845. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. This Notice may be available on a website that could be developed by the TAMHSC Health Care Provider. If a website is developed, you will be notified of the website address and you may obtain a copy of this Notice on that website.

Right to Opt Out of Receiving Fundraising Communications
From time to time we may contact you to raise funds for the benefit of TAMHSC. We will inform you how to opt out within each fundraising communication that we send to you.

Changes to This Notice
We reserve the right to change this Notice at any time. We reserve the right to make the revised or changed Notice effective for medical and billing information we already have about you as well as any information we receive in the future. The effective date of the revised

Notice will be on the first page, in the top right-hand corner. As of the effective date, distribution of the revised Notice that is in effect will be the same as above in the section describing your rights to receive a paper copy of the Notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the clinic location or with the Secretary of the Department of Health and Human Services. To file a complaint with the clinic location, contact the TAMHSC Privacy Officer, 200 Technology Way, College Station, Texas, 77845 or, The Secretary of the Department of Health and Human Services may be contacted at 200 Independence Ave., S. W.; Washington, D. C. 20201 or by phone at 1-877-696-6775.

HEALTH
TELEBEHAVIORAL CARE

Telebehavioral Care Program
Phone: (979) 436-0700 Fax: (979) 436-0062
health.tamu.edu/telehealth

Intake Questionnaire – Adult Personal History

A. Identification

Gender: (circle all that apply) male female transgender other: _____

Do you consider yourself to be spiritual or religious? (circle one) Yes No

B. Concerns

Please describe what concerns brought you to the clinic:

_____

_____

_____

C. Education

What is your highest level of completed education? _____

If you are currently a student, in what program are you enrolled? _____

Were you ever in special education? (circle one) Yes No

D. Health History

Have you ever had a head injury? (circle one) Yes No If yes, describe: _____

List any past and/or present mental disorders or psychiatric diagnoses: _____

_____

Describe any current medical problems: _____

_____

Have you ever received counseling or psychiatric care before? (circle one) Yes No

If yes, please describe what was helpful or not helpful: _____

_____

Please describe your past and/or present alcohol and drug use: _____

_____

E. Employment and Military History

Are you currently employed? (circle one) Yes No

Are you a veteran or active duty member of the military? (circle one) Yes No

Are you currently disabled? (circle one) Yes No If yes, please describe: _____

_____

In your opinion, is your ability to maintain a job currently limited by a mental health concern? Yes No

If yes, please explain: _____

_____

F. Family History

Relationship status: (circle all that apply) single married separated divorced widowed other: _____

With whom do you currently live? _____

Describe any family history of mental illness or alcohol/substance abuse: _____

_____

G. Children

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

H. Legal History

Are you currently involved in any legal proceedings? Yes No

Are you currently working with Child Protective Services? Yes No

I. Strengths

What do you do for self-care? (example: hobbies, interests) _____

_____

What are your top three personal strengths?

1. _____ 2. _____ 3. _____

Patient Health Questionnaire

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered at all**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	[ ]	[ ]	[ ]
b. Back pain	[ ]	[ ]	[ ]
c. Pain in your arms, legs, or joints (knees, hips, etc.)	[ ]	[ ]	[ ]
d. Menstrual cramps or other problems with your periods	[ ]	[ ]	[ ]
e. Pain or problems during sexual intercourse	[ ]	[ ]	[ ]
f. Headaches	[ ]	[ ]	[ ]
g. Chest pain	[ ]	[ ]	[ ]
h. Dizziness	[ ]	[ ]	[ ]
i. Fainting spells	[ ]	[ ]	[ ]
j. Feeling your heart pound or race	[ ]	[ ]	[ ]
k. Shortness of breath	[ ]	[ ]	[ ]
l. Constipation, loose bowels, or diarrhea	[ ]	[ ]	[ ]
m. Nausea, gas, or indigestion	[ ]	[ ]	[ ]

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	[ ]	[ ]	[ ]	[ ]
b. Feeling down, depressed, or hopeless	[ ]	[ ]	[ ]	[ ]
c. Trouble falling or staying asleep, or sleeping too much	[ ]	[ ]	[ ]	[ ]
d. Feeling tired or having little energy	[ ]	[ ]	[ ]	[ ]
e. Poor appetite or overeating	[ ]	[ ]	[ ]	[ ]
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	[ ]	[ ]	[ ]	[ ]
g. Trouble concentrating on things, such as reading the newspaper or watching television	[ ]	[ ]	[ ]	[ ]
h. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	[ ]	[ ]	[ ]	[ ]
i. Thoughts that you would be better off dead or of hurting yourself in some way	[ ]	[ ]	[ ]	[ ]

Suicidal Thoughts/Behaviors/Attempts: _____

_____

_____

3. Questions about anxiety.	**NO**	**YES**
a. In the last 4 weeks, have you had an anxiety attack - suddenly feeling fear or panic?	[ ]	[ ]

If you checked "NO", go to question #5.

	NO	**YES**
b. Has this ever happened before?	[ ]	[ ]
c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	[ ]	[ ]
d. Do these attacks bother you a lot or are you worried about having another attack?	[ ]	[ ]

4. Think about your last bad anxiety attack.	**NO**	**YES**
a. Were you short of breath?	[ ]	[ ]
b. Did your heart race, pound, or skip?	[ ]	[ ]
c. Did you have chest pain or pressure?	[ ]	[ ]

d. Did you sweat? .....[ ] [ ]
e. Did you feel as if you were choking? .....[ ] [ ]
f. Did you have hot flashes or chills? .....[ ] [ ]
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? .....[ ] [ ]
h. Did you feel dizzy, unsteady, or faint? .....[ ] [ ]
i. Did you have tingling or numbness in parts of your body? .....[ ] [ ]
j. Did you tremble or shake? .....[ ] [ ]
k. Were you afraid you were dying? .....[ ] [ ]

5. Over the last 4 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**
a. Feeling nervous, anxious, on edge, or worrying a lot about different things.....	[ ]	[ ]	[ ]

If you checked "Not at all", go to question #6.

b. Feeling restless so that it is hard to sit still	[ ]	[ ]	[ ]
c. Getting tired very easily	[ ]	[ ]	[ ]
d. Muscle tension, aches, or soreness	[ ]	[ ]	[ ]
e. Trouble falling asleep or staying asleep	[ ]	[ ]	[ ]
f. Trouble concentrating on things, such as reading a book, watching TV.....	[ ]	[ ]	[ ]
g. Becoming easily annoyed or irritable	[ ]	[ ]	[ ]

6. Questions about eating.	**NO**	**YES**
a. Do you often feel that you can't control what or how much you eat?	[ ]	[ ]
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	[ ]	[ ]

If you checked 'NO' to either #6a or #6b, go to question #9.

	NO	**YES**
c. Has this been as often, on average, as twice a week for the last 3 months?	[ ]	[ ]

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?	**NO**	**YES**
a. Made yourself vomit?	[ ]	[ ]
b. Took more than twice the recommended dose of laxatives?	[ ]	[ ]
c. Fasted - not eaten anything at all for at least 24 hours?	[ ]	[ ]
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	[ ]	[ ]

8. If you checked 'YES' to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	**NO**	**YES**
.....	[ ]	[ ]

	NO	**YES**
9. Do you ever drink alcohol (including beer or wine)?	[ ]	[ ]

If you checked "NO" go to question #11.

10. Have any of the following happened to you more than once in the last 6 months?	**NO**	**YES**
a. You drank alcohol even though a doctor suggested that you		

stop drinking because of a problem with your health .....[ ] [ ]

b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities .....[ ] [ ]

c. You missed or were late for work, school, or other activities because you were drinking or hung over .....[ ] [ ]

d. You had a problem getting along with other people while you were drinking .....[ ] [ ]

e. You drove a car after having several drinks or after drinking too much .....[ ] [ ]

Alcohol/Drug Abuse (Self or Family):

_____

_____

11. If you checked off <u>any</u> problems on this questionnaire, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
[ ]	[ ]	[ ]	[ ]

12. During the <u>last 4 weeks</u>, how much have you been bothered by any of the following problems?

	Not bothered at all	Bothered a little	Bothered a lot
a. Worrying about your health	[ ]	[ ]	[ ]
b. Your weight or how you look	[ ]	[ ]	[ ]
c. Little or no sexual desire or pleasure during sex	[ ]	[ ]	[ ]
d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend	[ ]	[ ]	[ ]
e. The stress of taking care of children, parents or other family members	[ ]	[ ]	[ ]
f. Stress at work or outside of the home or at school	[ ]	[ ]	[ ]
g. Financial problems or worries	[ ]	[ ]	[ ]
h. Having no one to turn to when you have a problem	[ ]	[ ]	[ ]
i. Something bad that happened <u>recently</u>	[ ]	[ ]	[ ]
j. Thinking or dreaming about something terrible that happened to you <u>in the past</u> - like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	[ ]	[ ]	[ ]

13. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? .....

NO	YES
[ ]	[ ]

History of Abuse (Child, Spouse, Physical, Sexual): _____

_____

_____

14. What is the most stressful thing in your life right now?

_____

_____

	NO	YES
15. Are you taking any medicine for anxiety, depression or stress?	[ ]	[ ]

Medications (please list): _____

_____

16. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

a. Which best describes your menstrual periods?

___ Periods are unchanged
___ No periods because pregnant or recently gave birth
___ Periods have become irregular or changed in frequency, duration or amount
___ No periods for at least a year
___ Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive

	NO	YES
b. During the week before your period starts, do you have a serious problem with your mood - like depression, anxiety, irritability anger or mood?	[ ]	[ ]
IF YES: Do these problems go away by the end of your period?	[ ]	[ ]
c. Have you given birth within the last 6 months?	[ ]	[ ]
d. Have you had a miscarriage within the last 6 months?	[ ]	[ ]
e. Are you having difficulty getting pregnant?	[ ]	[ ]

GAD-7

How often during the past 2 weeks have you felt bothered by:

		Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1	Feeling nervous, anxious, or on edge?				
2	Not being able to stop or control worrying?				
3	Worrying too much about different things?				
4	Trouble relaxing?				
5	Being so restless that it is hard to sit still?				
6	Becoming easily annoyed or irritable?				
7	Feeling afraid as if something awful might happen?				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

__Not difficult at all __Somewhat difficult __Very difficult __Extremely difficult

Developed by Dr. Robert L. Spitzer, Dr. K. Kroenke, et al.

PROMIS

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:	5	4	3	2	1
In general, would you say your quality of life is:	5	4	3	2	1
In general, how would you rate your physical health?	5	4	3	2	1
In general, how would you rate your mental health, including your mood and your ability to think?	5	4	3	2	1
In general, how would you rate your satisfaction with your social activities and relationships?	5	4	3	2	1
In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)....	5	4	3	2	1
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	Completely (5)	Mostly (4)	Moderately (3)	A little (2)	Not at all (1)
In the past 7 days…					
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	Never (5)	Rarely (4)	Sometimes (3)	Often (2)	Always (1)
How would you rate your fatigue on average?	None (5)	Mild (4)	Moderate (3)	Severe (2)	Very Severe (1)

How would you rate your pain on average?

☐ 0 No pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst pain imaginable