If you need to cancel or reschedule your appointment, please call our office 48 hours in advance or you will be charged a $175 late cancel fee or $250 no show fee.

We are pleased to welcome you as a new patient. It is our mission to provide you with comprehensive and compassionate health care.

Office Hours -	Monday - Friday 9:00am-4:30pm
Office Address -	3305 Northland Drive, Suite 401 Austin, TX 78731
Office Phone # -	512-419-0100

What to Expect During Your First Visit

During your initial evaluation, Dr. Skoglund will develop a personalized treatment plan to address your mental health needs. Your plan may include psychotherapy, medication management, lab tests, and/or other diagnostic tests. At the end of your session, Dr. Skoglund will ask to see you for a follow up two to six weeks after your first appointment.

During the 20-30 minute med check appointment, Dr. Skoglund will review the progress of your treatment plan and will make any changes that are appropriate. All medications have the potential for side effects and may require several adjustments to find the best dosage that is most helpful while minimizing side effects. It may take a few office visits to find the appropriate medication and dosage. It is important for you to realize the commitment and effort needed to achieve your potential.

Please complete the attached new patient paperwork and bring with you to your appointment.

Patient Registration Form

Name:_____
Last First MI

Address:_____

City:_____State_____ZIP Code_____

DOB:_____Age:_____E-mail address:_____

Cell Phone #:_____Home Phone #:_____

Emergency Contact:_____
Name Phone # Relation

Referred to Dr. Skoglund by:_____

Reason for visit: _____

CONSENT FOR TREATMENT

I voluntarily give full consent for the completion of an evaluation and authorize the provision of treatment as necessary until I otherwise notify Dan Skoglund, M.D. or the office manager.

_____ _____
Patient or Parent Signature Date

To develop your individualized treatment plan, it is important to gather detailed information about your medical, family, and social history. Use the back of the form if needed.

Medication History

Drug Allergies (if any)

_____ _____

_____ _____

_____ _____

All Medications You Are Currently Taking

Medication, Dosage, Directions, Prescribing Doctor

_____

_____

_____

_____

_____

_____

Prior Psychiatric Medications Taken in the Past

Medication, Dosage, Directions, Side Effects?

_____

_____

_____

_____

_____

Medical/Family/Social History

Your Medical History

If you are currently suffering from any medical or psychiatric conditions such as diabetes, hypertension, depression, bipolar disorder, addiction, etc., please list below:

Condition: _____

Condition: _____

Condition: _____

Condition: _____

Family History

If a family member is currently suffering from any medical or psychiatric conditions such as diabetes, hypertension, depression, bipolar disorder, alcoholism, etc., please list below:

Family Member:_____Condition:_____

Family Member:_____Condition:_____

Family Member:_____Condition:_____

Family Member:_____Condition:_____

Social Habits

Do you currently smoked tobacco or have you smoked in the past?

Circle One: Yes, currently Yes, in the past No, never

Do you consume alcohol? Circle One: Yes No

If yes, how many? Number of drinks_____per _____
(day, week, month)

Have you ever had a problem misusing or abusing, prescription medications?

Circle One Yes, currently Yes, in the past No, never

Have you ever had a problem with abuse or addiction with illegal drugs?

Circle One Yes, currently Yes, in the past No, never

Office Policies and Procedures

Our practice is committed to provide you with the highest standard of medical care. Your complete understanding of our office policies is an essential element of your care and treatment.

FEE SCHEDULE *

Initial Psychiatric Evaluation - 90 min.:	$450	Rate for Other Services: $75/15 min.
Medication Management – 30 min.:	$150	*Includes: Phone consults after office hours,
Rate for extra time at visit per 15 min:	$75	legal letters, disability paperwork, etc.

* All Fees are subject to change without notice

PAYMENT FOR MEDICAL SERVICES

Dr. Skoglund does not accept any insurance plans and does not file patient claims to your insurance. We accept cash, personal checks, MC/Visa, American Express, and Discover. Payment for services is due in full at the time of your appointment. Any financial concerns should be discussed prior to your appointment. If you cannot pay at the time of your visit, you will be asked to reschedule. If you have an insurance plan that will pay for out-of-network doctors (PPO), you may file your insurance claim with the receipt you receive at the end of your visit.

LATE CANCEL AND NO-SHOW POLICY

As a courtesy, our office gives appointment reminders one-two days in advance. You are responsible for keeping your appointment whether you receive the reminder or not. If you need to cancel or reschedule an appointment, please provide us with 24 hours notice or for Monday appointments, cancel by 12:00pm the previous Friday. This will allow us an opportunity to offer your appointment slot to another patient. We will charge a fee for missed or late canceled appointments. If you arrive 15 minutes or later to your appointment, you may be asked to reschedule. Patients who are consistently unable to keep their scheduled appointments will be asked to find another doctor.

PRESCRIPTION POLICY

- Plan ahead and allow 48 hours for refill processing. If you have no remaining refills, call your pharmacy and they will fax us a refill request. Medications such as Adderall are CII controlled substances that cannot be faxed or called to your pharmacy. Call the office to request the handwritten prescription that you must personally pick up.
- Unless written during your appointment, prescriptions for CII stimulant medications will require a $10 Rx management fee. Each additional triplicate written on the same day will be an additional $5.00 per script. If you lose your written prescription(s) and need Dr. Skoglund to re-write them, you will be charged $50.
- If you are not having regular appointments per Dr. Skoglund's orders, you may be charged $50 Rx fee to have your prescriptions refilled.

REPORTS, LETTERS, AND COMPLETION OF FORMS

Reports, letters, retrieving/copying/sending medical records, and related administrative work will be completed for a minimum of $50, depending on the complexity of the form and the matter in question. FMLA or disability paperwork and letters written by the doctor are charged per our fee schedule (listed above) based on his time to complete it. All paperwork must be paid in full before it can be released from our office.

I agree to the above stated financial and office policies.

Patient Signature _____ Date _____

Controlled Substance Policy

The purpose of this agreement is to protect your access to controlled substances and to protect Dr. Skoglund's ability to prescribe these medications to you. Controlled substances include Schedule IV medications for anxiety and sleep as well as Schedule II stimulant medications for ADD. Controlled substances have the potential for abuse and misuse; therefore, strict accountability of both patient and physician are required.

- All controlled substances prescribed for mental health purposes must be obtained from Dr. Skoglund only. Refills are provided at your appointment, so it is important to keep your follow up appointments.

- All controlled substances must be obtained from the same pharmacy. You are responsible for notifying our office if there are any pharmacy changes.

- Dr. Skoglund has permission to obtain, provide, and discuss information regarding controlled substances with dispensing pharmacists, other health professionals, and reports obtained by the DEA database.

- Take medication only as prescribed. If there are any changes in your symptoms, call and speak to Dr. Skoglund or schedule an office visit to discuss. Do not increase your dosage by yourself.

- Store your medications in a safe place that you will remember. Use a medication box to account for your daily use of medication. Do not share, sell, or permit others access to your medication.

- **Treat your medication with great care! Absolutely no early refills will be authorized by Dr. Skoglund regardless if your medication was stolen, lost, washed, flushed, or exceeding prescribed dosage.**

- Urine drug screens and appropriate blood tests may be done as part of your treatment plan. The presence of illegal substances or medications not prescribed may result in reassessment of your treatment plan and may result in dismissal from the practice.

- Dr. Skoglund will stop prescribing you controlled substance medications if you:
  - Abuse, overtake, sell, or misuse your medication
  - Repeatedly request early refills and/or increased doses
  - Have abnormal urine drug screens

Acknowledgment of Controlled Substance Policy

I affirm that I have read, understand, and accept the terms in the Controlled Substance Policy. I understand that if any of the above policies are violated or if I do not adhere to these policies, I will be terminated from this clinic and will not receive any refills from Dr. Skoglund.

_____ _____

Patient/Patient Representative Signature Date

PATIENT CONSENT FOR USE OF E-MAIL COMMUNICATIONS

ADULT PSYCHIATRIC CARE CENTER, P.A.

DAN SKOGLUND, M.D.

To better serve our patients, this office has established an e-mail address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at our e-mail address: admin@danskoglund.com. **Should you require urgent or immediate attention, an e-mail is not an appropriate form of communication. Please call 911 our office at 512-419-0100 instead.**

The typical turnaround time for routine patient communications by e-mail is two business days although the e-mail service provider may delay message delivery. When sending our office an e-mail, please include your name, phone number, and a detailed message so we can process it more efficiently.

Our office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to your messages. When communicating from your work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. Even when e-mailing from your home, you may feel that access to your e-mail is not well controlled, so you should take that into consideration before e-mailing our office. In addition, you should be aware that although your e-mail message may be addressed to Dr. Skoglund, his office staff has access to this information. **E-mail communications will be filed in your medical record.**

1. I understand and agree to the above e-mail policy.
2. I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.
3. By signing below, you agree that we may send medical related correspondence to you via e-mail and we may respond to your e-mails to our office via e-mail.

_____ _____

Patient Signature Patient E-mail Address – please print clearly

_____

Date

Acknowledgement of Review of
Notice of Privacy Practices

Contact Permission

In the event that Dr. Skoglund's office needs to contact you about your medical care, but is unable to reach you directly, please let us know if we could attempt any of the following alternatives. Please take into consideration that these messages could include information about your medication, test results, or other personal health information regarding your account with us.

If unable to contact me directly, I authorize Dr. Skoglund's office to:

- Leave a voice mail message at this phone number: _____
- Speak to or leave a message with the friends/family members listed below.

  - Name: _____Relationship_____
  - Name: _____Relationship_____
  - Name: _____Relationship_____

Disclosure of Health Information

Dr. Skoglund's office will not disclose any of your health information to family, spouse, friends or third parties such as medical offices and insurance unless you authorize us to do so in writing. Please indicate below the full name of all persons/facilities that you authorize to have access to your personal health information on file with us.

_____ _____

_____ _____

_____ _____

Review of Notice of Privacy Practices Acknowledgement

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Guardian Date

Insurance & Pharmacy Information:

Please provide your insurance information so we may use it if the medication you take requires a prior authorization.

Insurance Name: _____Member ID:_____

Policy Holder Name (if not patient): _____

Rx BIN# _____

Rx PCN # _____

Rx Group # _____

Your Pharmacy Name: _____

Pharmacy Address or cross streets: _____

Pharmacy Phone # _____