**Patient: _____**

## Welcome to The Costello Clinic

We would like to personally thank you for choosing us as your or your child's psychiatrist at this point in your personal journey. It is a difficult yet courageous decision to share one's innermost thoughts, feelings, and burdens with a professional. We hope we can work together successfully for your and/or your child's ongoing personal growth and development.

Our foremost goal is patient care. Feel free to ask any questions regarding your treatment or progress, and please let us know if there is a better way to assist you.

Please complete the following pages in this intake packet. We will be glad to discuss any questions you have regarding these forms and will provide you a copy of these forms upon request.

Additionally, let us address a few more details on how The Costello Clinic works. Office hours are available by appointment only, and all charges are for time reserved with us or used in your ongoing care. Payment for today and all future visits is due on the date of service by check, cash, VISA, MasterCard, Discover or American Express. Payments should be made payable to The Costello Clinic. **The Costello Clinic does adhere to a 24-hour cancellation policy**, meaning a minimum of a 24-hour (**one business day**) cancellation of any time reserved is necessary to avoid a **$75 missed appointment fee.**

The Costello Clinic strives to use an integrated team approach to treatment. Our practitioners typically focus on comprehensive psychiatric treatment. We may encourage, educate, direct, or provide psychological and social support recommendations or interventions as appropriate and individualized for each person provided care. Each Advance Practice Nurse works in collaboration with Dr. Louis Costello, and has specialized training in Psychiatry in addition to meaningful clinical experience and wisdom.

Finally, Urgent or Emergent calls should be directed to the answering service at 972-317-2082 to reach your practitioner or covering practitioner. Of course, if you are ever unable to reach us in an emergent situation, you are advised to seek appropriate emergent care.

Thank you in advance for taking care and making note of these important administrative details contained in this packet.

Best Regards,

Louis E. Costello, MD

**Patient Registration – Please ensure this form is fully completed.**

**Patient: _____**

Date: _____

**Patient Information**

| | | |
|---|---|---|
| Last Name | First | Initial |
| Address | | |
| City | State | Zip |
| Home phone | Work phone | |
| Cell phone | Alternate phone | |

Social Security Number: _____-____-_____ DOB ____-____-_____ Age: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race/Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other_____
Employed: ☐ Yes ☐ No Sex: ☐ Male ☐ Female Student: ☐ Yes☐ No

| | |
|---|---|
| Employer | Occupation |
| Employer Address | |
| City | State Zip |
| Work Phone | |
| Spouse's Name | Spouse's DOB ____-____-_____ |
| Spouse's Work # | Spouse's SSN _____-____-_____ |

Emergency Contact: _____ Phone # _____
Relationship to Patient: _____

Preferred Pharmacy, location, phone & fax number_____

Referral Source: _____ Specialty: _____
Referral Phone # _____

**By providing phone numbers, consent is granted for reasonable communication by these numbers, including voice mail. I agree to keep the office updated regarding changes to this information.**

**Is Patient a Minor? ☐ Yes ☐ No If Yes, then a parent/guardian must complete**

| | |
|---|---|
| Parent Name | Parent DOB ____-____-_____ |
| Address | Parent SSN ____-___-_____ |
| City | State Zip |
| Home phone | Work phone |
| Relationship to Patient | Employer |

_____

Signature of Patient/Parent/Guardian Date

**Assignment of Insurance Benefits for Payment from Your Insurance Carrier/Provider**

**Patient: _____**

**Insurance Carrier/Provider Name: _____**

**Phone number for Behavioral Health_____**

**ID #: _____**

**Group #: _____**

**Effective Date: _____**

**Insured Party (if other than patient)**

**Name: _____**

**Date of Birth: _____/_____/_____**

**Address: _____**

**SSN#: _____**

**Relationship to Patient: _____**

## Consent to Release Claims Information/Assignment of Benefits

I hereby assign, transfer and set over all right, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company.

I hereby consent for The Costello Clinic or any of its employees or agents to release and disclose any information required about me (or the above named patient) to my insurance carrier, claims administrator, managed care company, or review agency and their employees or agents for the purpose of treatment, healthcare operations, and evaluation of claims for payment.

I understand insurance billing is a service provided as a courtesy, and I am at all times personally responsible for any fees not covered by insurance. Should any insurance payment be made directly to me or I agree to immediately forward those funds to The Costello Clinic. I also acknowledge I am responsible for any deductible, co-pay, or any other balance not covered by my insurance carrier/provider.

Patient/Guardian Signature: _____Date:_____

Guarantor's Signature: _____Date:_____

Witness Signature: _____Date:_____

---

## Consent for Treatment

**Patient: _____**

I hereby authorize and give my voluntary consent to receive evaluation, consultation, and/or medications or treatment in the care of Dr. Louis Costello at The Costello Clinic or appropriate designate as considered necessary and advisable by the practitioner.

I understand I will be encouraged to participate actively in the formulation of a plan for my treatment. If I have any questions or concerns about this treatment plan, I may discuss these with the practitioner.

I understand the explanation about the services I will receive, and I agree to comply with the agreed upon evaluation or treatment strategies. I understand if any change in the treatment program is to be made, an explanation of the change will be given to me, and my consent for the change will be obtained before the treatment program change is made. I can expect to be advised of the benefits and risks of any treatments prescribed for me.

I acknowledge no guarantees have been made to me as to the result of this treatment.

I understand I may terminate my treatment from The Costello Clinic at any time.

If I am seeking evaluation, treatment, and/or care for a child, I acknowledge I have legal authority to seek and obtain voluntary outpatient psychiatric health services for this child.

| | |
|---|---|
| Patient/Guardian Printed Name | Date |
| Patient/Guardian Signature | Date |
| Witness Signature (For office use only) | Date |

**Patient: _____**

This form allows the exchange of information between The Costello Clinic and the person(s) to whom you grant consent below, especially your primary care physician and/or therapist. The goal of such information exchange is to coordinate your care as best as possible. The information exchanged may include psychiatric evaluation, treatment, medical, laboratory, and/or therapy information. **If the patient is 18 years or older and/or on their parent's insurance, it is advised to include parent's name and phone numbers on this consent form.**

Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____
Legal Guardian Signature Required if patient is under the age of 18

Patient's Primary Care Physician:
Name: _____
Address: _____
_____
Phone: _____ Fax: _____
I authorize the release of information to The Costello Clinic and for The Costello Clinic to release information to my (or my child's) primary care physician. This includes verbal communication between these persons or agencies.

Signature: _____

Patient's Therapist:
Name: _____
Address: _____
_____
Phone: _____ Fax: _____
I authorize the release of information to The Costello Clinic and for The Costello Clinic to release information to my (or my child's) therapist. This includes verbal communication between these persons or agencies.

Signature: _____

Patient's _____:
Name: _____
Address: _____
_____
Phone: _____ Fax: _____
I authorize the release of information to The Costello Clinic and for The Costello Clinic to release information to my (or my child's) _____. This includes verbal communication between these persons or agencies.

Signature: _____

Patient's _____:
Name: _____
Address: _____
_____
Phone: _____ Fax: _____
I authorize the release of information to The Costello Clinic and for The Costello Clinic to release information to my (or my child's) _____. This includes verbal communication between these persons or agencies.

Signature: _____

This above release is subject to revocation by the above signed at any time except to the extent that action has already been taken. Revocation must be submitted in writing. The Costello Clinic is not responsible for confidential information which is passed on to any party not named in this release.

## HIPAA

**Patient: _____**

## Acknowledgement of Review of Notice of Privacy Practices for The Costello Clinic and the Office of Louis Costello, M.D.

I have reviewed The Costello Clinic Notice of Privacy Practices which explains how patient medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I request it.

Print Patient Name

Signature of Patient or Guardian Relationship

Date

Witness Signature (For office use only)

**Patient: _____**

## Patient-Provider Partnership Agreement (page 1 of 4)

### Prescriptions and Refills

Refills are routinely handled by fax or electronic transmission. When you have seven days of medication left, please contact your pharmacy and have them contact The Costello Clinic for a refill. Please allow 3 - 5 business days, after you have contacted your pharmacy, for all refill requests. **If you are not current with your appointments, refill requests may be denied.**

### Guidelines for Continued Care

- The patient will only be considered an active patient of this practice if the patient keeps each appointment or makes alternative appointments with this office.
- After the passage of four months without contact between the practitioner and the patient, the patient may be considered an inactive patient.
- Inactive status designates that the practitioner will reserve the right to direct triage to another provider or facility if the need arises. Only emergency triage will be provided. If medication has been prescribed continuously by the practitioner and inactive status occurs, a maximum of one month of medication may be prescribed while the patient finds an alternative healthcare provider.
- Inactive status may be instituted after two appointments missed with less than 24 hour cancellation notice.

### Consent for Treatment

- I have voluntarily chosen to receive treatment and understand that I may terminate treatment at any time. It is recommended that patients discuss their desire to terminate treatment with the practitioner prior to termination.
- I authorize and request my practitioner to carry out psychological examinations, treatments and/or diagnostic procedures, which now or during the course of my treatment are designated to be helpful, my practitioner can make no guarantees about the outcome of my treatment. I agree to participate fully in my treatment.

### Complaints You May Have with Your Insurance

You may discuss complaints directly with your practitioner at any time regarding your care or clinic billing issues.

The Costello Clinic is a private pay clinic. Insurance benefit appeals and grievances are handled between you and your insurance company or their designee.

You have the right to request an appeal in the case that visits are denied certification with your insurance company or their designee. You risk nothing in exercising this right. The Texas Department of Insurance is responsible for regulating healthcare services. You may contact Texas Department of Insurance at (800) 252-3439 or www.tdi.state.tx.us

## Patient-Provider Partnership Agreement (page 2 of 4)

### Financial Agreements

**Patient: _____**

| Our fees are as follows: | **Usual & Customary** |
|---|---|
| Clinicom Diagnostic Psychological Testing (Must be prepaid) | $ 75 in office $ 50 at home |
| Initial Psychiatric Diagnostic Evaluation | $550 |
| Ongoing Care Visit, 15 minutes, low complexity | $140 |
| Ongoing Care Visit, 17 - 37 minutes, low complexity | $250 |
| Ongoing Care Visit, 17 - 37 minutes, moderate complexity | $300 |
| Ongoing Care Visit, 38 - 52 minutes, moderate complexity | $400 |
| Ongoing Care Visit, 53 - 60 minutes, moderately complex | $525 |
| All Other Services, $550/hour, prorated in 10 minutes increments | $550/hour |
| Late Cancellation, less than 24-hour or one business day notice | $ 75 |
| Missed Appointment Fee | $ 75 |
| Check Returned for Insufficient Funds | $ 45 |
| Controlled Schedule II Prescriptions requested between appointments | $ 20 |
| Contacting NP after hours for Emergency Medication Needs | $ 45 |

**Clinicom:** Prior to every patient's initial visit with The Costello Clinic, a Clinicom questionnaire will be completed. The Clinicom is a self-paced diagnostic tool that can take between two to two and half hours to complete. The questionnaire generates a 22 page report which is read by Dr. Costello prior to the first face-to-face appointment with each patient. **The Clinicom fee is $75.00 or $50.00 dependent upon location, which is paid by every new incoming patient seen at The Costello Clinic.** The Clinicom is not covered by many of the major insurance companies. If you would like to see if your insurance company will reimburse you for this charge, you may do so. We will provide you with the superbill for the testing.

**Court Fees**: If a deposition or opinion in court is required, there is a $550 per hour charge. The minimum charge is $1,650 paid in advance. The hourly charge is billed for preparation time, travel time, and any time spent with an attorney/clerk for preparation. Travel costs will also be billed from door-to-door.

**Medical Records**: Copies of Psychiatric Medical Records are not typically printed and provided to the patient. $30 for the first twenty pages and $.75 per page for every copy thereafter, or $30 per CD copy provided. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. If an affidavit is requested, certifying that the information is a true and correct copy of the records, an additional fee of $30 will be charged for executing the affidavit.

**Letters/Documentation**: The charge will be determined by the amount of time spent to complete the request.

**Phone Calls to Practitioners:** At the discretion of your clinician, we reserve the right to charge $ 90 for every 15 minutes the clinician is on the phone with a patient. Telephone fees are not covered by your insurance, and charges associated with them are solely your responsibility.

**Appointments**

Initial appointments will generally last 60 minutes. Follow-up appointments are usually 30 or 45 minutes.

**Patients who arrive more than 15 minutes after their scheduled appointment time, will not be seen**. They will be rescheduled (and assessed the $75 missed appointment fee) so that other patients can be seen on a timely basis. Payment is expected in full at the time of service, or you will be asked to reschedule when payment can be made. Missed appointment fees are not covered by your insurance, and charges associated with them are solely your responsibility.

If you are using your insurance benefits, you agree to assign payment from your health plan to The Costello Clinic. It is your duty to notify this office if you have a change in insurance coverage. You are responsible for obtaining prior authorization/certification for treatment from your insurance company or their designated organization. Failure to do so may result in you being billed for that appointment. **We will bill your insurance company if we are a contracted provider; however, you are responsible for co-payments, deductibles, and payment for services not covered by your health plan.** If you have a deductible, you must pay for your visits until the deductible has been met. These payments are payable at each appointment.

## Patient-Provider Partnership Agreement (page 3 of 4)

## Cancellation and Missed Appointment Policy

**Patient: _____**

Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with fewer than 24 hour notice, you will be responsible for the fee. Repeated "no-show" appointments could result in you being referred out of the clinic to another practitioner. Your insurance company will not be billed for fees associated with cancelled or missed appointments, the patient will be solely responsible for payment of their fees.

## Patient-Provider Partnership Agreement

- I will be honest and report progress (or lack thereof), side effects, or any dangerous thoughts immediately when the session begins.
- I will follow all recommendations regarding medications and, particularly, regarding protections for safety.
- I will inform The Costello Clinic of all hospitalizations (including Intensive Outpatient Treatment and Partial Hospitalization Programs) of psychiatric nature.
- I understand my provider may call 911 if necessary to protect safety. This may occur without discussion if the patient does not immediately present a plan for safety when deemed clinically reasonable by the provider.
- I understand my prescription may not last between appointment intervals. I understand I need to contact my pharmacy to have a refill fax request sent to The Costello Clinic when I have seven days of medication left. I understand if emergency refills are authorized by the clinician on call after-hours (nights/weekends), only enough medication to last to the next business day may be authorized.
- I understand that if Controlled Schedule II Prescriptions are requested between appointments a $20.00 fee will be assessed.
- I understand there is a non-wavering protocol for disability services. I also understand all fees associated with paperwork and calls to the disability carrier are not insurance reimbursable and must be paid before the paperwork will be completed.
- I understand all fees are expected to be paid at the date and time services are rendered. Nonpayment may result in a referral to another provider.
- I understand in an effort to focus treatment and provider results, my practitioner(s) will evaluate progress on an ongoing basis. If improvement is not significant as would be expected for your condition, the practitioner may refer you to a new clinic. Our practitioners do not believe it is ethical to continue treatment with no clear results and restoration to previous functioning or reasonable maintenance of clinical status. New "eyes" may be needed in these circumstances.

Patient/Guardian Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

---

## Patient-Provider Partnership Agreement (page 4 of 4)

## Fee Items which are YOUR responsibility and are not covered by insurance

**Patient: _____**

When you cancel an appointment with less than 24 business hours you will be assessed a late cancel fee of $75.00. When you do not show up for an appointment, or arrive 15 minutes (or later) after your scheduled appointment time, you will not been seen and you will be assessed the $75.00 missed appointment fee.

## Controlled Prescription Policies

CII prescriptions are highly controlled and followed by the State of Texas. **Due to administrative requirements placed on our clinic, it is now necessary for us to implement a $20.00 fee on CII prescriptions for those requested between office visits** (this is for medications such as Adderall, Concerta, Daytrana, Focalin, Quillivant, Ritalin and Vyvanse etc.)

If you request a prescription during a regular office visit, there will be no fee assessed to you. If you fail to have the medication filled within the required 21 day period, if you lose the prescription, or if you need a refill and do not have a set appointment (you must be approved by the clinician to pick up meds in between appointments), the $20.00 fee will be assessed to you. **The prescription WILL NOT be given to you until the fee is paid.**

## Guidelines regarding prescriptions, refills, and emergency medication refills after hours

For each patient current and future, we would like to clarify our medication refill guidelines and practices. It is our belief, in general, refills are handled best at the time of your face-to-face visit with your practitioner**. Please review and be ready with your medication refill requests at the time of your face-to-face visits.**

**All other refills not handled during your face-to-face visit will be handled by fax when appropriate** (with the exception of controlled prescription policies specifically covered below). **When you have 1 week remaining on a prescription, contact your pharmacy and request a prescription refill.** They will fax a refill request to our office. Please allow five (5) business days for all refill requests, once you have contacted your pharmacy. **If you are not current with your face-to-face TCC practitioner appointments, your refill request may be denied.**

If the above is not possible, the patient can visit a local emergency room or emergent care clinic for an emergency supply of medication. **If a clinician is paged for an emergent medication refill, a $45.00 fee will be assessed to you at the clinician's sole discretion.** Additional service time will be billed in 10 minute increments at $480/hour under our current agreement for "All other Psychiatric services".

If you have any questions or concerns, please feel free to address those with the provider. Thank you for your attention to this matter. I have had an opportunity to read and discuss this with office staff.

| Patient/Guardian Printed | Signature | Date |
|---|---|---|
| Office Witness printed name | Office Witness Signature | Date |