



**Family Care, Bryan**  
2900 E. 29<sup>th</sup> St.;  
Bryan, TX 77802  
PH: (979)776-8440

**Behavioral Health**  
2900 E. 29<sup>th</sup> St.  
Bryan, TX 77802  
PH: (979)776-8440

**Family Care, Navasota**  
1905 Dove Crossing Ln, Suite A  
Navasota, TX 77868  
PH: (936)825-0755

**Psychiatry**  
8441 Riverside Pkwy  
Bryan, TX 77807  
PH: (979)774-8200

**Telebehavioral Care**  
PH: (979)436-0700

## Office Hours

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

Tuesday, Wednesday, and Friday  
8AM – 5PM

**Psychiatry**  
Monday-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

**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 before your scheduled appointment**. New patients should arrive at least **30 minutes before 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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**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.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO PERSONAL REPRESENTATIVE**

I, \_\_\_\_\_, hereby authorize to have my information released to the following individuals. This authorization 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

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Relationship

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Relationship



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**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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**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 provide 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 incurred 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**
  - **Authorization 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 30<sup>th</sup>.
- 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*