AURA MD
PREMIER PSYCHIATRY SERVICES

Please return this paperwork to our office via the Elation Passport Portal 48 hours in advance of your scheduled appointment. This is to allow your provider to review your pertinent medical history and ongoing issues allowing us to better understand and develop a comprehensive, individualized treatment plan specifically for your needs.

- When sending completed paperwork, you must generate a new message to send this document as an attachment. Do not reply to our initial message. Please create your own new message and attach the paperwork.
- Please use a laptop/desktop to attach your initial documents. Other than the initial patient paperwork, you can use conveniently use your mobile, tablet or desktop device for all messaging purposes moving forward.

This process is done in an effort to allow Dr. Toutounchi or Brandon Provost, NP to review your medical history and ongoing issues prior to hour appointment which allows your provider to better understand and develop a comprehensive, individualized treatment plan for you!

Please Download the Elation Passport app for easy messaging in the future after your initial appointment!

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PATIENT INFORMATION SHEET

Today's Date:_____ Provider: Ashley Toutounchi, MD
Brandon Provost, NP

Name:_____ Date of Birth:_____ Cell Phone:_____

Home Address:_____(street, apt/suite if applicable)

_____ (city, state, zipcode)

Marital Status: Single Married Divorced Sex: ☐ M ☐ F Occupation:_____

EMERGENCY CONTACT: Name:_____ Relationship:_____

Phone:_____

INSURANCE:

Health Insurance Name: _____ Policy Holder Name:_____

Subscriber ID#:_____ Group #:_____

Presciption Group Number:_____ Prescription Plan Name:_____

Prescription Coverage Phone Number:_____

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NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment, and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations, such as quality assessment and physician certifications
- Confirmation of appointments

I have received, read, and understand the Notice of Privacy Practices. I understand this organization has the right change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations.

I authorize Aura MD to release any medical information necessary for processing claims for the services provided. I authorize the payment of medical benefits to Aura MD for services provided. I understand that I remain responsible for any charges not met by my insurance company and will be charged any delinquent balance after it is 60 days past due to your confidential method of payment on file.

Patient Name _____ Date:_____

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OFFICE POLICIES AND PROCEDURES:

Dear Patient-
At AuraMD, are dedicated to providing you with quality medical care and excellent customer service. Our patients are important to us and we are working diligently to enhance our services and inform you of any policies or procedures that may affect you as our patient. Below, we have listed several changes to our operational policies and procedures:

- You will be updated at the beginning of each calendar year as to any policy/ procedural changes and required to sign in agreement in order to continue care at Aura MD.

- Please remember that it is ultimately your responsibility to have the appropriate amount of medication on hand. A fee will be assessed for refills of a controlled substance without an appointment. Please be aware- current Texas law regulates that any stimulant prescription automatically expires 21 days after the earliest fill date. It is your responsibility to be mindful of this.

- You can view your upcoming appointments at any time by logging into the Elation Patient Portal at any time.

- Please arrive a few minutes ahead of your scheduled appointment to allow time for check-in. Most of our regular appointments are scheduled for 15 minutes. Therefore, if you are even a couple minutes late you may need to reschedule or wait until there is an open spot. The provider may require the full 15 minutes of your appointment, so we're not able to just "squeeze you in."

- Legal Testimony: It is often unforeseen but legal matters requiring the testimony of a mental health professional can and do arise. Legal testimony can often be damaging to the relationship between a patient and his/her therapist or physician. As such, we require that you employ independent forensic psychiatric services should this type of evaluation or testimony be required.

Patient Signature: _____ Date:_____

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PATIENT RIGHTS & RESPONSIBILITIES

- Patients have the right to personal privacy and confidentiality of information.
- Patients have the right to receive information about managed care services, practitioner and clinical guidelines, and patient rights and responsibilities.
- Patients have the rights to reasonable access to care, regardless of race religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to participate in an informed way in the decision-making process regarding their treatment planning.
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- Patients have the right of members' families to participate in treatment planning, as well as the right of members over 12 years old to participate in such planning.
- Patients have the right to individualized treatment, including:
    - Adequate and humane services regardless of the source(s) of financial support
    - Provision of services within the least restrictive environment possible
    - An individualized treatment or program plan
    - An adequate number of competent, qualified clinical staff to supervise & carry out treatment plan.
- Patients have the right to participate in the consideration of ethical issues that arise during care.
- Patients have the right to designate a surrogate decision maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Patients and their families have the right to be informed of their rights in a language they understand.
- Patients have the right to voice complaints or appeals about a managed care company or the care provider.
- Patients have the right to make recommendations regarding managed care company rights and responsibilities policies.
- Patients have the right to be informed of rules and regulations concerning patients' conduct.
- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.
- Patients have the responsibility to participate & understand their behavioral health symptoms and establish collaboratively with their healthcare provider mutually treatment plan goals.

Patient Signature: _____ Date:_____

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Consent for Treatment:

Patient Name:_____

I, do, voluntarily authorize such treatment involving routine diagnostic procedures and medical/psychotherapeutic treatment as considered appropriate by the patient's provider. I understand that my provider will obtain my informed consent (or of parent or legal guardian) prior to treatment with any methods that are considered to include significant risk. I am aware that the practice of medicine is not exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examination to be rendered.

I have been provided with a copy of the Patient Rights and Responsibilities.

Patient's Signature: _____ Date:_____

Parent/Guardian Signature (if applicable): _____
*By my signature, I certify that I am the parent/legal guardian and my power to consent to treatment has not been removed/limited.

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FINANCIAL POLICY

I understand that payment is expected at the time of service. Payment can be made by cash, or credit card. We require at least a 1 business day notification on cancellations (see Cancellation Policy for further details). Otherwise, there will be a cancellation fee without exception unless there is documentation to indicate an emergent situation that was beyond the patient's control. No future appointments will be scheduled until your account is cleared. This credit card on file will also be used for any delinquent balance after 90 days that is not covered by your insurance.

This cancellation fee will be assessed to your credit card on file on the date of missed appointment, which is held confidentially with no accessibility by staff/physician to your credit card information except the last 4 digits of card number.

The credit card listed below will be put confidentially on file for this purpose and please understand that because we specifically reserve your appointment slot for you, this is why we implement this policy.

I authorize Ashley Toutounchi, MD, PA to charge my credit card listed below:

Type of Card (please circle) ___Visa ___Mastercard ___ Discover ___AmEX

Credit Card #_____

Expiration Date: _____ Three or Four Digit security Code:_____

Name on the Card: _____

Billing address on the card: _____

I have read and understand the office policies of Ashley Toutounchi, MD, PA. I acknowledge and agree with all policies listed. I understand my financial obligations for treatment received from Ashley Toutounchi, MD, PA, as stated above, and agree to pay for any and all services according to Aura MD policy.

CardHolder Signature: _____ Date:_____

Print Card Holder Name:_____

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PRACTICE POLICIES:

We strive to ensure that your appointment promptly begins at the schedule time; therefore, we ask that all patients arrive on time for their appointments. I make every effort in honor your time and my patients and hope that we can reciprocate that common goal. Aura MD implements the following policies:

_____ It is the patient's responsibility to keep track of scheduled appointments. Our office will send a courtesy text reminder 2 days prior to your appointment reminding you of your appointment date and time. However, it is ultimately the responsibility of the patient to keep track of all appointments.

_____ If you wish to increase, decrease or discontinue your medication, please call the office first to discuss before making any changes. Changes without clinician consent are potentially dangerous and may interfere with our ability to work together in a Clinician-Client Relationship moving forward.

_____ Any patient receiving controlled substance prescriptions must see an Aura MD provider for a scheduled medication management follow-up at least once every 3 months.
Refills will not be issued without a required appointment.

_____ A signed authorization is required to release any information on a client. If we not do not have a current authorization on file, we will not release any information regarding medical records, appointment dates/times, or payment information. If anyone can call on your behalf, please make sure you complete a release form allowing us to release information to whomever you designate.

Patient Signature: _____ Date:_____

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OFFICE FEES: Please read and initial each item.

_____ **Psychiatric Assessment/Consultation.**

45 minute appointment, initial diagnostic assessment, review of prior psychiatric history & development of treatment plan.

- Adult Assessment (45 min) $350

_____ **Medication Monitoring Appointment.**

Appointment (15 minutes) to assess progress on pharmacotherapy treatment and refills or change treatment plans as necessary.

--Dr. Ashley Toutounchi: $139 --Brandon Provost, NP: $119

Once established in the practice at Aura MD, you are free to make follow-up appointments with either provider.

_____ **24 hour Cancellation Policy.**

If you are unable to keep your schedule appointment, please contact the office at least 24 hours in advance to avoid being charge an appointment fee**.** If you miss your appointment and without the proper notification, you will be charged **$110 fee.**
This is not covered by insurance.

(i.e. if you have an appointment on Monday 3pm, we require notification by Friday at 3pm, or Wednesday 10am appointment requires notification by Tuesday 10am).

We deliver quality care to all of our patients and with less than 1 business day notice, we are not able to fill your appointment slot. We work very hard to be present and on time for your appointments and appreciate that reciprocated for our time as well.

_____ **Controlled Prescriptions.**

Any lost and/or stolen controlled substance prescription(s) must be reported directly to the police department before a new prescription can be issues. A replacement controlled substance prescription will not be issued without a police report.
A **$50** fee is charged for replacing each lost/stolen/expired controlled substance prescription without exception.

_____ **Paperwork.**

Completion of paperwork for medical leave, disability, medication cost assistance, etc., will incur a fee based on time and complexity. Forms/ letters completed outside of your appointment time will incur the following fees:

Standard Letter	$45.00	FMLA or Disability Paperwork	$150.00
Complex (over 30 minutes)	$225	Emotional Support Animal Letter	$295

_____ **Delinquent Balance.** This credit card on file will also be used for any delinquent balance after 90 days.

Patient Signature: _____ Date:_____

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You give permission to Ashley D. Toutounchi, MD, PA (Aura MD) to communicate with you by email and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/text notification, and how we use email/text communication. It will also be used to document your consent for communication with you via email and text message.

1. How we will use email and text messages: We use these methods to communicate only about non-sensitive and non-urgent issues. You will receive appointment reminders via text which will not contain any patient information involved in your medical care. It is provided as a courtesy from Aura MD to help ensure compliance with appointments to avoid no-show or late cancellation fees and keep our office working efficiently and effectively for you, our patient.
   -All communications to, or from you, may be made a part of your medical record. You have the same right of access to such communications as you do the remainder of your medical record. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.
2. The Elation Passport is our online portal system that is streamlined for ease of communication. This is the best way to get in touch with our office regarding medication refills or if you need to leave a message for your provider. As always, in event of an emergency, you should directly call 911 and the portal is not designed to handle emergent or acutely urgent issues.
3. Withdrawal of consent: I understand that I may revoke this consent at any time by so advising Aura MD in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.
4. Client Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form.
   I understand the risks associated with the use of email and text messaging as a form of communication between Aura MD staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that Aura MD may use to communicate with me by email or text message.

Patient Signature: _____ Date:_____

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PATIENT CLINICAL HISTORY

Name: _____ Age:_____ Height: _____ Weight: _____

**Pharmacy Name & Address : _____

**Pharmacy Phone: _____

How did you hear about us? ❍Family/Friends ❍ Google ❍ Yelp ❍Therapist

Were you referred? If so, by whom? _____

What is your primary complaint that brings you into the office today?_____
_____

Stressors in your current daily life: (i.e. health issues, loss of loved one, financial, relationship). What changes or goals would you want to achieve from treatment regarding your emotions, behavior or daily functioning?

_____
_____
_____

If you were to rate your mood, 1 being the worst and 10 the best, what is your mood currently?

❍1 ❍2 ❍3 ❍4 ❍5 ❍6 ❍7 ❍8 ❍9 ❍10

Have you ever had mood so low that you had thought of harming yourself in any way? ❍Yes ❍No
If so, by when and how?_____

Please list any current medications (prescribed or over the counter)
Specify med/dose/how many times/day
1. _____
2. _____
3. _____
4. _____

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Do you have any known medical conditions? Check all that apply

- ❍ Acid Reflux
- ❍ Seizure
- ❍ Sleep Apnea
- ❍ Gallbladder Issues
- ❍ Chronic Pain
- ❍ Diabetes
- ❍ h/o Cancer
- ❍ Migraine
- ❍ Anemia
- ❍ h/o Heart Attack
- ❍ Hot Flashes
- ❍ Kidney Stones
- ❍ High Blood Pressure
- ❍ Hypothyroidism
- ❍ Autoimmune Disorder
- ❍ Osteoporosis

Pertinent Complaints/Symptoms: Check any of below symptoms that you have experienced.
Please designate whether current (in past month) or past (more than a month ago)

- ❍ Unable to Pay Attention
- ❍ Unable to Sit Still/Fidgety
- ❍ Disorganized/Forgetful
- ❍ Sad/Depressed Mood
- ❍ Excessive Feelings of Guilt/Shame
- ❍ Crying Spells/Easily Tearful
- ❍ Low Self-Esteem/Self-Image
- ❍ Too Little Sleep
- ❍ Too Much Sleep
- ❍ Appetite Decrease
- ❍ Appetite Increase
- ❍ Weight Gain If so, how much? _____
- ❍ Weight Loss If so, how much? _____
- ❍ Low Energy/Fatigued
- ❍ Low Libido/Unable to Orgasm
- ❍ Isolating from Friends/Family
- ❍ Conflict/Problems at Work
- ❍ Problems Getting Along with Others
- ❍ Nightmares
- ❍ Repetitive Actions (e.g. hand washing, irrational counting, symmetry etc)
- ❍ Thoughts of Suicide
- ❍ History of Suicide Attempt
- ❍ History of self-mutilation/cutting
- ❍ Excessive Worry
- ❍ Panic Attacks
- ❍ Excessive Concern About Safety/Health
- ❍ Extreme Anger outbursts/History of Violence
- ❍ Mood Swings/Irritability
- ❍ Irresponsible/Impulsive Behaviors
- ❍ Excessive Energy
- ❍ Not needing to sleep as typical and not feeling tired
- ❍ Feeling too happy/elated for no reason/euphoric
- ❍ Spending Sprees/Thrill Seeking
- ❍ Excessive Fear of Something Specific
- ❍ Excessive Shyness/Self-Conscious
- ❍ Hoarding Items Not Needed
- ❍ Hearing or Seeing Things Others Don't
- ❍ Thoughts of Harming others
- ❍ Episodes of Severe Confusion for No Reason
- ❍ Preoccupied with Beliefs others disregard as

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Prior Psychiatric Medications:

Medication:	When and for how long?	Response: (positive, negative; side effects)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Types of past treatment: please specify if med management or counseling/therapy. Also, include with whom, when and for how long._____

When were you last treated by that provider?_____

What diagnoses have you been treated for in the past? (ex: anxiety, depression, bipolar, ADHD)_____

_____

Have you ever been hospitalized for any psychiatric reason? (indicate below)

When	Where	Reason
_____	_____	_____
_____	_____	_____

Other Medical History:

Any history of repeat concussions or head injuries? _____

Any prior surgeries?_____

Any current physical complaints?_____

Please use this space for any additional pertinent medical information to share with us about your state of health

_____

_____

Do you have any allergies to any medications? _____

Social History:

Are you currently: ☐ married ☐ divorced ◯ single ◯ in a relationship ◯ separated

Do you have any children? If so, what ages? _____

Are you currently working? If so, where and for how long? _____

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How far did you go in school? Highest level of education? (GED/high school, bachelor, graduate) _____
Do you have any history of sexual/physical abuse? If so, at what age, for how long and by whom?_____
_____

Do you have any current legal issues? ❍Yes ❍No

If yes, of what nature? _____

Have you ever been arrested? If so, when and for what reason _____

Have you ever been arrested for drug/alcohol related charge? ❍Yes ❍No

Substance Abuse History:

Do you drink alcohol? OYes ONo

If yes, how many days/week? _____ How many drinks in one day? _____

Have you ever felt you couldn't control your alcohol consumption? ❍Yes ❍No

Have others around you ever criticized or were concerned about your drinking? ❍Yes ❍No

Do you use any tobacco products (e-cig, chewing tobacco, cigarettes etc)? ❍Yes ❍No

If yes, how much/day and for how many years? _____

Are you currently motivated to stop smoking/tobacco use? ❍Yes ❍No

Have you ever used any illicit/street drugs and/or abused any prescribed medications)? ❍Yes ❍No

If so, please specify which substance, how much and for how long? When was most recent use?_____
_____

Have you ever been to rehab for a drug/alcohol problem? ❍Yes ❍No

Family History:

Has anyone in your family been diagnosed with any psychiatric illness? ❍Yes ❍No

If so, whom and what were they diagnosed with? _____

Has anyone in your family ever completed suicide? ❍Yes ❍No

If yes, by whom? _____

We thank you for sharing your medical symptoms and history with us so that we can provide you with the most effective and appropriate treatment plan. Please don't hesitate to let us know how we can better assist you.