

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
Telephone Hours -	Monday - Friday	9:00am-4:00pm
Office Address -	3305 Northland Drive, Suite 401 Austin, TX 78731	
Office Phone # -	512-419-0100	
Email Address -	admin@danskoglund.com	

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 4-6 weeks after your first appointment.

Follow Up Appointments

During your 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.

New Patient Registration Form

Name: _____
Last First MI

Address: _____

City: _____ State _____ ZIP Code _____

DOB: _____ Age: _____ E-mail address: _____

Best Phone # to Contact You: _____

Emergency Contact: _____
Name Phone # Relation

Referred to Dr. Skoglund by: _____

Reason for visit: _____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

Even though we do not accept any insurance, we may need your information if your insurance requires a prior authorization for your medication.

Insurance Name: _____ Member ID: _____

Rx BIN #: _____ RxPCN #: _____ Rx Group #: _____

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 smoke 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

OFFICE HOURS

Our office hours are Monday-Friday 9:00am-4:30pm. Any messages left after 4:30pm will be returned the next business day. We do not check voice mail or email at night or on weekends. If you have an emergency after business hours, you can call the Medical Exchange 512-458-1121 to page Dr. Skoglund.

PAYMENT

Payment for services is due in full at the time of your appointment. We accept cash, MC/Visa, American Express, and Discover. If you cannot pay at the time of your visit, you will be asked to reschedule.

Dr. Skoglund does not accept any insurance plans including Medicare and does not file patient claims to your insurance. We will provide you with a detailed receipt that can be used to file a claim for out-of-network benefits.

FEE SCHEDULE

Follow Up Med Check 30 min \$200 Psychiatric Evaluation 90 min: \$550

Med Check/Therapy 60 min \$375 Extra Appt Time: \$100/15 min.

SCHEDULED APPOINTMENTS

A medication management appointment is normally completed within 20-30 minutes. If you know ahead of time that you will need additional time for your appointment, please inform our office when scheduling. This will help us keep schedule delays to a minimum and reduce frustrations for other patients waiting for their appointments. We will require future appointments to be scheduled for more time for patients whose sessions go over on time on a regular basis.

After your session, you are expected to schedule your next appointment. If you need to call back at a later date to schedule your follow up, remember that the schedule fills quickly. This may limit your options for dates and times. It is your responsibility to contact us.

REMINDER CALLS

As a courtesy, our office sends appointment reminders 1-2 days in advance. You are responsible for keeping your appointment whether you receive the reminder or not. Please make sure that our office has your correct email address and phone number.

If you need to cancel or reschedule an appointment, please provide us with 24 business hours notice. This will allow us an opportunity to offer your appointment slot to another patient. We will charge a \$100 fee for missed or

late cancelled appointments. Exceptions to this policy may be granted for emergency situations only. After 3 missed appointments, you will be terminated from the practice.

If you arrive 10 minutes or later to your appointment, you may be asked to reschedule and may result in a missed appointment fee.

MEDICATION REFILLS REQUESTS

- Prescriptions with refills are written at scheduled appointments. It is the responsibility of the patient to schedule appointments BEFORE you run out of refills.
- Stimulant medications are CII controlled substances and cannot be called into your pharmacy. You may request a refill by email or calling our office directly. Controlled substance refills sent in between office visits will be charged a \$10 Rx management fee.
- All other medication refills should be requested from your pharmacy even if have no remaining refills or your refills expired. Allow 48 hours processing time. To check the status of your refill request, please contact your pharmacy. We typically can approve your refill the same business day. Calling our office about your refill request delays our ability to process all patient requests.
- If you are not having regular appointments per Dr. Skoglund's orders, you may receive a partial refill until you have an appointment.

REPORTS, LETTERS, AND COMPLETION OF FORMS

Reports, letters, or paperwork written by the doctor are charged per our fee schedule based on his time to complete it. Allow at least 3 business days to complete. 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

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

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. **Dr. Skoglund does not prescribe any opiate medications under any circumstances.** 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

CREDIT CARD CHARGE AUTHORIZATION

Patient Name: _____

Card Holder's Name: _____

Card Holder's Relation to Patient: _____

Card Holder's Billing Address: _____

Card Holder's Phone #: _____

Visa/MC/Discover Amex CC# _____

Expiration Date: _____

Security Code: _____

I authorize Dan Skoglund, MD to keep my credit card information on file to use for payment of telehealth appts, controlled medication refills, after-hours charges, late cancelled or missed appointments, or other charges not listed with the exception of in-office appointments.

I understand that this authorization can be cancelled at any time by requesting in writing. The cancellation will not affect any payments already processed prior to the receipt of the cancellation notice. I also agree that it is my responsibility to ensure that Dan Skoglund, MD has received the cancellation notice.

Signature of Patient and/or Card Holder

Date

OFFICE USE ONLY

Received:

Verbally

In-Person