BALANCED MINDS
Zuraima Caldera, M.D.
Child and Adolescent & Adult Psychiatry

Balanced Minds PLLC
2901 Caballo Ranch Blvd,
Bldg 6, Ste D
Cedar Park, TX 78641
Phone: 512-851- 1220

Balanced Minds PLLC
PATIENT INFORMATION

Date:____/____/____

Last Name:_____ First Name:_____ M Initial:_____

Nickname:_____ Age_____

Sex (circle): M F Soc. Sec #:_____-____-_____ DOB: _____/____/____

Marital Status: _____

Race (Ethnicity):_____ Language spoken at home:_____

Home Address:_____ City:_____ State:_____

Zip:_____

Home Phone: (___)_____ Cell Phone: (___)_____

Work Phone: (___)_____

Email: _____@_____

Best way to contact you:_____

Employer:_____Occupation:_____

Who referred you?:_____ Phone: (___)_____

Fax#: (___)_____

Address:_____ City:_____ State:____

Zip:_____

I would like my referral source contacted about my psychiatric care (circle) Yes No

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CAREGIVER INFORMATION (LEGAL GUARDIAN IF CHILD/ADOLESCENT)

Name:_____ Age:_____ Sex

(circle): M F

Relationship with patient:_____

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Address (if different than above): _____City:_____ State:____

Zip:_____

Home Phone: (___)_____ Cell Phone: (___)_____

Work Phone: (___)_____

Email: _____@_____

Best way to contact you:_____

Employer:_____

Occupation:_____

CAREGIVER INFORMATION (LEGAL GUARDIAN IF CHILD/ADOLESCENT)

Name:_____ Age:_____ Sex

(circle): M F

Relationship with patient:_____

Address (if different than above): _____City:_____ State:____

Zip:_____

Home Phone: (___)_____ Cell Phone: (___)_____

Work Phone: (___)_____

Email: _____@_____

Best way to contact you:_____

Employer:_____

Occupation:_____

EMERGENCY INFORMATION:

Emergency Contact:_____ Relationship:_____

Phone:(___)_____

Drug Allergies:_____

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MEDICAL INFORMATION:

Primary Care Doctor: _____ Phone: (___)_____ Fax#:

(___)_____

Address:_____ City:_____ State:____

Zip:_____

I would like my primary care physician contacted about my psychiatric care (circle) Yes No

Preferred Pharmacy: _____ Phone: (___)_____

Fax#: (___)_____

I would like to get appointment reminders by (circle as many options as you want):

Email Text message Voice reminders to my phone

In order to be able to obtain controlled substances prescriptions, I give consent to retrieve prescription history when request is triggered. Circle one option. Yes No

_____ _____

Patient's signature Date

_____ _____ _____

Legal Qualified Representative Relationship Date

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Balanced Minds PLLC
CONSENT FOR EVALUATION

I do hereby consent to psychiatric evaluation/treatment by Balanced Minds PLLC. I understand that the provider at this office will explain my or my child's condition(s), possible risks versus benefits, and methods of treatment for my or my child's condition(s) before treatment is provided.

_____ _____
Patient's Name Date

_____ _____
Signature Patient/Guardian/Caretaker Date

Relationship to the Patient:_____

_____ _____
Provider Date

CONSENT FOR TREATMENT
(To be signed at the end of first visit)

I fully understand this Form and I have had the opportunity to discuss my or my child's condition(s) with the care provider. All my questions have been adequately answered.

_____ _____
Patient's Name Date

_____ _____
Signature Patient/Guardian/Caretaker Date

Relationship to the Patient:_____

_____ _____
Provider Date

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Balanced Minds PLLC
CONSENT FOR FINANCIAL RESPONSIBILITY

Thank you for choosing Balanced Minds PLLC to provide you with psychiatric care. We are committed to provide you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship and it should be signed before care is rendered. Please ask if you have any questions about our fees, financial policy, or your relationship as our patient.

- It is every patient's responsibility to pay all services rendered in this office, including any charges for missed appointments as outlined below
- Payment is due at the time of services. I consent to a credit card number being stored in my file for charges such as missed appointments, telephone calls, telemedicine encounters, physician statement.
- I understand that Balanced Minds PLLC and Dr. Caldera are out-of-network providers, and that it is my responsibility to determine what, if any, reimbursement I will receive from my insurance company. Any insurance claims are responsibility of the patient. I also understand that it is my responsibility to discuss with my insurance company how to file said claim. The office billing sheet will contain all the codes and information necessary to file the insurance claim.
- Professional fees are as follow:
    - Children and Adolescents Initial Psychiatric Evaluation 90 Minutes: $599
    - Adults Initial Psychiatric Evaluation 60 minutes: $399
    - Adults Medication management Follow up appointment 30 minutes encounter: $199
    - Children and Adolescents Medication management Follow up appointment 30 minutes encounter: $199
    - Psychotherapy Appointments 50 minutes encounter: $399
    - Phone Consultation 15 minutes encounter: $99
    - Copies of records 20 pages: $35
    - Telephone medication refill: $45
- At least one month's notice will be provided in case of any changes in the fee charged.
- There is a $50 fee for all returned checks.
- If you do not show up for an appointment or cancel with less than 24 hours' notice for an established patient visit or 48 hours in advance for a new patient, you will be charged the full amount of your visit. You must pay this fee before you can schedule a new appointment. Patients with three missed appointments may be terminated from the practice.
- Cash, checks, debit and credit cards are the accepted forms of payment.

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PATIENT OR LEGAL GUARDIAN

I have read, understand, and have been allowed to ask questions about this policy and Consent for Financial Responsibility. I agree to comply with the guidelines above as described.

Signature _____

Printed Name _____ Date _____

Relationship to Patient (If applicable):_____

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Balanced Minds PLLC
OFFICE POLICY CONTRACT

Welcome to Balanced Minds PLLC. Thank you for choosing us as your provider for psychiatric care. This letter describes certain policies and procedures that help us meet the needs of all of our patients. Please read it carefully and any questions that you may have we can discuss then at our next meeting. Once you sign this, it will constitute a binding agreement between us.

Contact Information
Office hours are Monday-Friday 10:00 AM-4:00 PM. If you need to reach our office between appointments, please call the main office number at 512-851-1220 and leave a message. You can also e-mail the office at info@balancedmindsatx.com. We will return your call within 24 business hours or e-mail within 72 business hours. In case of life threatening situations, or if you feel that you might hurt yourself or someone else before the doctor is able to speak with you or return your call do not wait for a return call. You should dial 911 or go to the nearest emergency department.

Appointment Information
Prior to your first appointment you should have been submitted the "Package of Forms for New Patients" by fax at 512-851-1080 or by mail to 2901 Caballo Ranch Blvd Building 6 Suite D Cedar Park, TX 78641, and we should have coordinated the first appointment together. It is important that we have current contact information (correct phone numbers, addresses, best way to contact you) so that we are able to inform you of any scheduling or policy changes. Please provide current information if changes are made. First appointment is meant to be a consultation to formulate diagnosis assessment as well as treatment plan, and to decide if our services are a good fit for your needs. Additional visits may be needed to make this determination. Also this will give you the opportunity to determine if our services are a good fit for you.

You should ***arrive at least 10 minutes before your actual appointment time***. Your appointment is time set aside for you, which is why there is very little waiting for your appointment. We make a priority to start your appointment on time. If you are late for your appointment, then your time with the doctor will still end as scheduled so the doctor can see the next patient on time. If you are more than 15 minutes late for your appointment, we will let you know if you can be seen or if you should be rescheduled and you still will be charge for that visit. If the doctor is late in seeing you, you will still be seen for the full amount of time unless clinical emergencies require the shortening of your appointment.

Most initial appointments are for 60 minutes for adults and 90 minutes for minors, although some initial appointments may be longer. Office visits are by appointment only. Follow-up appointments are for 20 to 50 minutes. You should always bring your medications or the current list of your medications to your appointments. Also, you most bring in prescription bottles before any controlled prescriptions be issued (benzodiazepines, or stimulants)

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Follow up appointments will be scheduled each time you are seen in most cases. You may e-mail info@balancedmindsatx.com or call 512-851-1220 to schedule a follow up appointment. You will be contacted within one business day to schedule the appointment. If you need to reschedule, please do so per the appointment policy described below.

Cancelling and rescheduling appointments

At Balanced Minds PLLC we strive to provide timely appointments for our patients and we request that all patients keep their appointments. We have a no-show policy that includes late cancellations. A late cancellation is a cancellation made after 12:00 noon the business day before your appointment for follow up appointments, and 48 hours before your appointment for new patients. A no-show appointment is any appointment, in which you don't show, or you arrive 15 minutes late, and you do not contact the office prior to your scheduled appointment. A full fee will be charged for any late cancellation or missed appointments. If any patient has three late cancellations or no-shows in a 12 month period, Balanced Minds PLLC may terminate care, and a letter will be mailed to you to this effect.

If you need to cancel or reschedule your appointment, please call 512-851-1220 at least 24 hours prior to your appointment time for follow ups, and 48 hours prior to your appointment time for first appointment.

Medication refills

New prescriptions and refills will be provided during office visits. In case of refills been needed between visits, please allow the doctor at least 72 hours to call in the refill. Do not wait until your prescription runs out. Contact your pharmacy, not this office, to begin the refill process at least 2-3 days before running out of your medication. Even if the prescription says 0 refills, the pharmacy will submit a refill request to this office. You should contact this office for refills on controlled substances (benzodiazepines or stimulants). Please note that you must keep follow up appointments or your medications will not be refilled. If you fail to show for 3 appointments or have not been seen in a 6 month time period, no medication will be refilled until you schedule an appointment and are seen at our office. In the rare event that a phone refill is needed please leave a message with information regarding your name, phone number, date of birth, name of medicine, strength, dose and frequency of the requested medication and the pharmacy name and phone number.

Lab Work and Results

It is important for your health to get labs done in a timely fashion once they ordered by your doctor. Some medications require regular monitoring as blood level can vary, and some medications can affect your liver, kidneys, blood sugar level, electrolytes, cholesterol, and other aspects of your health. Once we receive labs results, we will review them. Within 1 week of having your labs drawn, you will receive a phone call with the results, and you may get a copy of the results at your next visit. If it has been more than 1 week after a lab draw, and you have not gotten the results, then please contact the office.

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You should call the lab to make sure they have your correct insurance information and to find out why they are billing you. It may be that you are responsible for a deductible. Occasionally a test may not be covered by your insurance and the lab will bill you.

Confidentiality

Protecting the confidentiality of your personal information is an important obligation that we take seriously at Balanced Minds PLLC. We respect your privacy and we will maintain all records of your treatment on confidential basis. We will not disclose any information about you or your treatment without your written consent, unless we are required or are allowed to do so under applicable law.

You may obtain copies of your records by requesting them in writing and paying the applicable fee. You will be provided with the copies of the records unless we determine that doing so may be harmful for your emotional or mental health, in which case I will be happy to provide them to an appropriate mental health professional of your choice.

Requests for help with forms and legal problems

Sometimes we complete forms to allow patients to take a temporary absence from school or work. We also sometimes help patients with forms for health insurance. We may require an appointment with your psychiatrist to complete your paperwork. This appointment must be separate from a standard appointment in order to ensure that proper time is scheduled for form completion.

Although we can help with some forms, our mission is to provide psychiatric care. We do not deal with legal matters. In some cases, we will not be able to complete paperwork if you have not been established with the clinic for a certain period of time, or if the paperwork requires information that we are not able to provide. At any point, your psychiatrist can decline to complete paperwork because it is not appropriate to be completed by our office. We do not write reports for child custody issues, lawsuits or for defense against criminal charges, worker compensation injury papers, or for other legal purposes.

Insurance plans

This practice does not accept insurance. It is our policy to have patients fill out and monitor their own insurance claims. It is the patient's responsibility to discuss with their insurance company how to files aid claim. The amount of reimbursement from the insurance company will depend upon the insurance policy. The office billing sheet will contain all the codes and information necessary to file the insurance claim. If you are eligible for Medicare or are presently receiving Medicare medical benefits, please be aware that Balanced Minds PLLC and Zuraima Caldera, MD have opted out of billing Medicare. This means that you will not be able to send our statement to Medicare for reimbursement.

Payments

Please read and sign the Consent for Financial Responsibility.

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Behavioral rules

A good patient/physician relationship and good medical care are based on mutual respect and polite and appropriate behavior. Therefore, all interactions at Balanced Minds PLLC must be respectful and appropriate.

If a patient or family member damages equipment, furnishing, building, property, or grounds in or around Balanced Minds PLLC, the patient is financially responsible for damage and will make prompt restitution.

Termination of Relationship

You may terminate our professional relationship at any time by providing us with notice. We may terminate our professional relationship at any time, subject to our ethical obligations and the rules of the Texas Medical Board, by providing you with notice. We will provide you with a list of alternative providers from whom you may seek any additional psychiatric services.

Your signature below indicates that you have read the information in this document, understand all that it contains, and agree to abide by its terms during our professional relationship.

_____ _____
Patient's Name Date

_____ _____
Signature Patient/Guardian/Caretaker Date

_____ _____
Provider Date

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Balanced Minds PLLC
PATIENT CONSENT FOR USE AND DISCLOSE OF PROTECTED HEALTH INFORMATION

_____, hereby states that by signing this consent I acknowledge and
Patient name

agrees as follow:

1. I have received the Office's privacy notice prior to my signing this consent. The privacy notice includes a complete description of how the office uses or discloses my protected health information (PHI). The office has stated that this notice is available to me in the future at my request, and I have the right to obtain a copy for my records

2. The office reserves the right to change its privacy practices that are described in its privacy notice, provided it is permitted by law.

3. I understand and authorize the following appointment reminders that will be used by this office: a telephone call to my home, work, or cell phone (by my preference of best way to contact me) and leaving a message on my answering machine or with the person with whom may answer the phone in an appropriate way (simply leaving the doctor's name and time of appointment) when I am unavailable or do not have a private voicemail to leave a message; and/or email reminders, and/or appointment cards handed out with my first name, date and time.

4. I understand that appointment reminders are a courtesy and it is still my responsibility to record and keep any appointments that I have made, and it may not be guarantee that I will successfully receive a reminder every time.

5. I understand that it is the policy of the office to speak the name of the next patient, when sending patients to their appropriate room, into the waiting room where other patients may be present. Last names are used when two patients of the same first name are waiting to be called for accuracy.

6. I understand that the office may send a letter to my home if I have missed two appointments without contacting this office to inform me of the termination policy or to mail me lab results if I was not able to be contacted by phone or e-mail. Any mail will be marked **Personal and Confidential**.

7. I understand that it is the policy of the office to contact patients who have not been in for a while in the following manner: a) telephone call to my home or work (by my preference of best way to contact me) and leaving a message on my answering machine or with the person with whom may answer the phone in an appropriate way; b) letter reminders that are mailed to my home address.

8. I understand that I have the right to request that the office restrict how my PHI is used and/or disclose to carry out treatment, payment and/or health care operations. However, the office is not required to agree to any restrictions that I have requested. If the office agrees to a requested restriction, the restriction is binding on the office.

9. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions. If I do not sign this consent, Balanced Minds PLLC may decline to provide treatment to me.

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Patient's signature		Date
Legal Qualified Representative	Relationship	Date

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Balanced Minds PLLC
PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

EFFECTIVE 04/14/2003

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Balanced Minds, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers, and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

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B. **For Payment.** We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket, and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. **For Health Care Operations.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to insurance carriers.

D. **Quality Assurance.** We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. **Utilization Review.** We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. **Credentialing and Peer Review.** We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. **Appointment Reminders and Health Related Benefits and Services**. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine or email) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. **Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

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J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is “de-identified.”

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers’ Compensation. We may disclose medical information about you for your worker’ compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers’ compensation insurance or a state workers’ compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

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- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental, or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

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W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. **Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

Balanced Minds PLLC
2901 Caballo Ranch Blvd,
Bldg 6, Ste D
Cedar Park, TX 78641
Phone: 512-851- 1220

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

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C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information.

To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a

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pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office.

When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Balanced Minds PLLC
Attn: HIPAA Officer
2901 Caballo Ranch Blvd Building 6 Suite D Cedar Park, TX 78641
Phone #: 5128511220

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

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In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____
Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____

BALANCED MINDS
Zuraima Caldera, M.D.
Child and Adolescent & Adult Psychiatry

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CREDIT CARD CHARGE AUTHORIZATION

I understand that the credit card listed below will be charged for services rendered and for the missed and cancelled appointments with less than a 24-hour notice. If the credit card charge is denied, I will be billed separately for the appointments. Balanced Minds PLLC will not schedule any further appointments until I pay all outstanding balances. I agree to call and notify the clinic, in advance of my next schedule appointment, if my address, phone number, or responsible party has changed. I hereby authorize Balanced Minds PLLC to charge my credit card for services rendered to me or the patient whose name appears below (and for appointment missed or cancelled with less than 24-hour notice)

Credit Card #:_____ Security Code:_____ Exp. Date:_____
Name (as printed in card):_____
Billing Address (As on card Statement):_____
City:_____ State:_____ Zip Code:_____

By signing below, I am authorizing Balanced Minds PLLC to charge my credit card for the professional services as described above. I certify that I am the owner of the credit card listed on this form and can authorize charges to this card.

Patient's Name _____ DOB:_____
Signature (Responsible Party):_____ Date:_____

BALANCED MINDS
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TELEPSYCHIATRY INFORMED CONSENT

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

In order to receive telepsychiatry services from Balanced Minds PLLC, you must be a **Texas State Resident**.

Balanced Minds PLLC allows Dr. Caldera to perform telepsychiatry for any appointment after the initial in-office evaluation, but only through the telemedicine service provider Doxy.me, LLC. The interactive electronic systems used by Doxy.me incorporate network and software security protocols to protect the confidentiality of patient information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential telepsychiatry benefits include reduced wait time to receive psychiatric care, patient convenience, avoiding the need to travel to a psychiatrist, increased accessibility to psychiatric care, and increased privacy and confidentiality; as you, the patient, would not have to travel to the clinic but would be able to attend appointments from the comfort of your home or office, or any place of your choosing (within the state of Texas). Potential Telepsychiatry Risks include that telepsychiatry session will not be exactly the same, and may not be as complete as a face-to- face service; information being transmitted over the internet, in some instances, may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision-making by Dr. Caldera. Also, delays in psychiatric evaluation and treatment could occur due to deficiencies or failures of the equipment (although the appointment could be concluded over the telephone at no extra charge). Other risks include failure of security protocols resulting in a breach of privacy of the patient's confidential medical information. In rare cases, a lack of access to all the information that might be available during an in-office visit, but that may occur in a telepsychiatry session, could result in the omission of care involving other health problems or possible adverse drug interactions, also a lack of access to all the information that might be available in a face to face visit, but not in a telepsychiatry session, may result in errors in judgment.

If Dr. Caldera decides that the benefits outweigh the risks, she may request telepsychiatry sessions when the patient schedules follow-up appointments. If Dr. Caldera agrees, the patient will be scheduled for a telepsychiatry session, and will be sent an internet link (to http://Doxy.me) via email or telephone with instructions to log into the “waiting room” immediately prior to my scheduled appointment.

BALANCED MINDS
Zuraima Caldera, M.D.
Child and Adolescent & Adult Psychiatry

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Patient Rights ("I" and "My" refers to you the patient): (1) I understand that all laws protecting the privacy and confidentiality of medical information also apply to telepsychiatry. (2) I understand that all the Texas rules and regulations which apply to psychiatry also apply to telepsychiatry. (3) I understand that my psychiatrist has the right to withhold or withdraw his consent for the use of telepsychiatry at any time during the course of my care. (4) I understand that I have the right to withhold or withdraw my consent for the use of telepsychiatry at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my psychiatrist.

My Responsibilities: (1) I understand that I must be physically within Texas (including offshore State waters) to be eligible for telepsychiatry, and my psychiatrist can send prescriptions for medications only to Texas pharmacies or addresses. I will inform my psychiatrist as soon as my session begins of my physical location. (2) I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because the computer, tablet, or mobile telephone I use must have working camera and audio input so that my psychiatrist can see and hear me in real time. (3) I will not record any telepsychiatry sessions without prior written consent from Dr. Caldera and I understand that my psychiatrist will not record any of my telepsychiatry sessions without my prior written consent. (4) I will inform my psychiatrist as soon as my session begins if any other person can hear or see any part of our session. (5) If I lose my connection during a session, I will immediately attempt to log back into the http://Doxy.me “waiting room.” (6) If the audio I am receiving during a telepsychiatry session is not complete and clear, I will attempt to let my psychiatrist know or connect via telephone to complete the appointment or schedule a new appointment.

Patient Consent to the Use of Telepsychiatry: I have read and understand the information provided above regarding telepsychiatry. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize Dr. Caldera to use telemedicine in the course of my diagnosis and treatment. I agree to hold Balanced Minds PLLC and Dr. Caldera harmless from injuries or omissions that may be related to the malfunction or technical failure of equipment or system encryption.

_____

Printed name Date

_____

Signature of patient (or parent, legal guardian, or conservator) (Relationship to patient)