Zoraya Ahumada, M.D.,PLLC
4550 Post Oak Place Dr., ste 252,
Houston, TX, 77027
(346) 704-0077

CHILD AND ADOLESCENT PATIENT INFORMATION

Please complete the information about the patient below to enable us to communicate with you according to our necessity and your preferences.

Name of Patient: _____Date of Birth __/___/_____

Legal Guardian: _____ Date of Birth ___/___/_____

Address _____ City _____ State____

Zip Code_____

Guardian Address (if different than above):

_____

Medication Allergies:

_____

Primary Pharmacy: _____ Phone #: (_____)_____

Pharmacy Address:

_____

(Street) (City) (Zip)

Referred By: _____

Emergency Communications

Emergency Contact _____Relationship_____

Emergency Contact Phone: _____

TELEPHONE COMMUNICATION

Please only leave contact information for phone numbers where you will be willing to accept an incoming call from our office. Also indicate if we can leave a message.

Preferred Contact Number _____ Home_ Cell_ Work_

Can we leave a message? Yes No

Other contact Number _____ Home_ Cell_ Work_

Can we leave a message? Yes No

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ELECTRONIC COMMUNICATION

Please provide your email address if you consent to email communication with Dr. Ahumada.

Email Address (print carefully)

_____

•Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

•Communications via Gmail or other email communications are not encrypted but still considered part of your health record.

•Any text or email initiated by yourself is an implicit consent to receive electronic communications from our office with in the same medium, i.e. sending an email to Dr. Ahumada's website email account implies agreement to receive a reply via Gmail

•Emails should not be used to convey sensitive information or to discuss urgent or emergency issues. Please call the office to speak with Dr. Ahumada about your medical care.

I have read, understood and agree to the above guidelines on electronic communications.

Signature _____ Date _____.

Late Cancellations, Missed Appointments, and Source of Payment

YOU WILL BE CHARGED FOR MISSED APPOINTMENTS UNLESS YOU PROVIDE 24-HOUR NOTICE. 24 HOUR NOTICE CAN BE GIVEN AT ANY TIME VIA EMAIL OR TEXT NOTIFICATION: **hello@zorayaahumadamd.com or (346) 7040077**

PLEASE NOTE THAT INSURANCE WILL NOT REIMBURSE FOR MISSED APPOINTMENTS. BY SIGNING, YOU AGREE THAT ALL CHARGES ARE YOUR RESPONSIBILITY AND THAT FILING FOR OUT-OF-NETWORK INSURANCE REIMBURSEMENT IS YOUR RESPONSIBILITY IF YOU CHOOSE TO DO SO.

Signature of Guarantor: _____Date _____

Name of Guarantor (Printed) _____Relationship _____

If different from patient above:

Home Address _____Zip_____

Preferred Contact Number

_____

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Demographic and Clinical Information

Grade Level _____ Accommodations at school (if any, ie 504 plan) _____

Name of School/Teacher _____ Religion (optional)_____

Please List any extracurricular activities that your child participates in (i.e., sports, clubs, band, etc.)

_____ _____

_____

_____

_____

Please list all individuals living in your household including parents, children, partners, spouse etc.

Name	Age	Relationship	Occupation

Please list all family members not living in your present household.

Name	Age	Relationship	Occupation

How were you referred?

_____

Please briefly describe the problem or situation that has led you to seek treatment:

_____

_____

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Has your child ever experienced this problem before? If so, when and what treatment did you receive if any?

_____

_____

Do you have any particular treatments in mind? If so, what?

_____

_____

Name of Primary/family doctor: _____

Name of other current treating providers _____

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Points to Remember for Patients and Guardian

1. Notify Dr. Ahumada if there are any significant changes in your child's psychiatric or medical condition.

2. Notify Dr. Ahumada of any significant changes at home or school that may affect your child's care.

3. Notify Dr. Ahumada if you suspect or know that your child is pregnant. Pregnancy will affect treatment recommendations

4. If you feel your child is at any risk of hurting him/her or others, notify Dr. Ahumada immediately.

5. If any medication makes your child drowsy or slows down his/her reaction time, have your child refrain from driving and notify Dr. Ahumada. Also notify Dr. Ahumada if your child's medication causes other significant side effects.

6. If you or your child wants to increase, decrease, or discontinue prescribed medication regimen or start a new medication/supplement/"natural" remedy, call first. Medication management is a collaborative process. Changes without consultation are potentially dangerous and may interfere with our ability to work together.

7. It is advised your child not drink alcohol while taking psychiatric medications.

8. Please note our office does not provide reminder calls about upcoming appointment. You will be responsible for keeping track of them.

9. All cancellations are made by calling or texting Dr. Ahumada at (346)704-0077 or email at hello@zorayaahumadamd.com

I have read and understand the preceding Points to Remember.

_____ _____

Guardian Signature. ***Date***

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Professional Fees (as of August 1st 2018)

Initial Phone Consultation and Screening: No Charge

Psychiatric Consultation (Child 13-17 year old): requires 2 sessions= $700 total

• The first session will be with the child/adolescent and family together. 60 minutes for gathering complete medical, psychiatric, developmental, educational, social and family history. $400

• The second session will be meeting with the child/adolescent alone for 30 minutes, followed by a feedback session to discuss diagnosis and recommended treatment plan for an additional 30 minutes. $300

Psychiatric Consultation (Child younger than 12 years old): requires 3 sessions= $800 total

• The first session will be with the parents alone. 45 minutes for gathering complete medical, psychiatric, developmental, educational, social and family history. $300

• The second session will be with the child alone for 45 minutes. $300

- The third session will consist of a feedback session to discuss diagnosis and treatment plan with parents and child for 30 minutes. $200

• The content of the sessions may vary based on the discretion of the provider.

If, after the in person consultation, Dr. Ahumada is felt to be an appropriate provider for the patient, the following fees will apply for follow up visits:

Psychotherapy (various modalities): $300 per session (typically 45 minutes)

Medication management: $200 per session (typically 20-30 minutes).

Combination medication management and psychotherapy: $300 per session (typically 45 minutes)

Forms and Letters:

Patients frequently request forms and letters for school, work, or insurance issues. If time permits, brief forms may be completed during your allotted appointment time and there will be no additional charge. Longer forms and letters will be done outside of appointment times and the feel will be based on the time involved to complete this services.

• Simple (less than 5 minutes) No Charge

• Moderate (5-15 minutes) $30

• Lengthy (15-30 minutes) $75

• Complex (over 30 min) $150/hour

ZA

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Phone Calls

Brief phone calls are an important part of monitoring an individual's response to treatment. These calls should be made during regular office hours and there is no fee. If I am not available to receive the call, I will make every effort to return the call that same day or evening. If calls are increasing in duration and frequency, this may be a sign that you need to be seen sooner. You will be asked to schedule an appointment. Non emergent call made after hours will be billed at $300 an hour.

Copying Records:

Upon written request, records will be copied. It typically takes a week to have copies made. Copies of charts can be picked up or mailed, but will not be faxed. The fee for copying is:

- $25.00 for the first 20 pages
- $0.50 for each subsequent page

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PATIENT INFORMATION REGARDING PROFESSIONAL FEES

The purpose of this agreement is to clarify your financial responsibilities and allow us to focus on what is most important to all of us—helping you.

Payment is expected at the time of service. Accepted methods of payment include cash, check, online payment via Zelle and credit card (Visa, MasterCard, American Express, Discover).

If you prefer to use Zelle or Paypal please specify here_____ (email or phone number) to which you are linked to on your Zelle account and the payment will be requested after the visit. You can also pay via Zelle or paypal directly using this email: hello@zorayaahumadamd.com

Please note there is a 3.5% credit card fee if using a credit card for payment. Checks should be made payable to Zoraya Ahumada MD PLLC. Having the office charge your credit card at the time of service is encouraged because it simplifies the checkout process for you and the office.

I UNDERSTAND THAT I WILL BE CHARGED THE FULL APPOINTMENT FEE FOR MISSED APPOINTMENTS AND CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. I am aware that insurance will not reimburse charges for missed appointments or late cancellations.

I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE TO THIS OFFICE ALL INFORMATION NECESSARY TO OBTAIN PREAUTHORIZATION PRIOR TO TREATMENT. I understand I may be charged for the time involved in obtaining preauthorization.

I understand that there is a $25 fee plus any bank fees that may apply for returned checks with insufficient funds.

It is our policy to designate one parent as financially responsible for services provided to children. If court orders (e.g. Custody agreements) specify other financial arrangements (e.g. each parent responsible for 50%), it becomes the responsibility of the designated parent to obtain reimbursement from non-designated parent.

The office requests to keep your credit card information on file to charge for missed appointments or late cancellations.

I authorize Zoraya Ahumada MD PLLC to charge my credit card.

My credit card # is _____ Auth #_____ Exp _____ Zip_____

I agree to advise Dr. Ahumada when I come in of any change in my address, phone number,

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marital status, or responsible party that has occurred since my last appointment.

THE FINANCIAL RESPONSIBILITY FOR SERVICES PROVIDE IS YOUR RESPONSIBILITY AND INSURANCE IS FOR YOUR REIMBURSEMENT. We do not bill the insurance company directly. Your statement contains all information needed to file with your insurance.

Although interest will not be charged routinely, we reserve the right to charge interest at the rate of 10% per annum and bill for all expenses incurred if your account has to be turned over to collections and/or an attorney. Similarly, we will charge to recoup returned check fees.

If you have any questions regarding this agreement, do not hesitate to discuss with Dr. Ahumada.

Patient's Name _____ Date_____

Responsible Party's Name _____ Date _____

Responsible Party's Signature _____ Date _____

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CONFIDENTIALITY

PLEASE READ CAREFULLY

Generally speaking, communications between a patient and mental health provider are confidential and may not be disclosed without your consent, or as otherwise provided by law.

There are exceptions to the general rule of confidentiality which would require that the mental health provider report his or her concerns without the consent of the patient. These occasions include, but are not limited to, the following:

• Belief that child abuse has or may occur

• Belief that a mentally handicap or elderly person has been or may be abused

• Reports by a patient of possible sexual abuse or exploitation by a previous therapist.

An instance where you are felt to pose an imminent danger to yourself or another person may result in a loss of confidentiality, and your physician may be compelled to release your records, give a deposition, and/or testify in court.

Similarly, if you are involved in a suit- affecting the parent-child relationship, your physician/therapist may be compelled to release your records, give a deposition, and/or testify in court.

Special rules apply to minors: By law, a parent has the right to the medical record of the child, unless this right has been limited by court action. Parents, on the other hand, may agree that during the course of treatment given to a minor child, they will waive the right to the medical record of their child. I have found that this waiver is helpful for useful clinical work to occur.

If you have any questions or would like more information, please feel free to ask.

****

Acknowledgement by patient: I have read the preceding, and understand my rights as a patient.

_____ _____

Patient Signature Date

Parent Waiver (encouraged but optional): I am willing to waive my right of access to communication between my child and their physician/therapist and grant to the physician/therapist the discretion to determine when or if such communication would be shared by me

_____ _____

Parent Signature Date

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Zoraya Ahumada MD PLLC

NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice, please contact our Privacy Officer who is Zoraya Ahumada MD 4550 Post Oak Place Dr., ste 252, Houston, TX, 77027 (346) 704-0077

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician’s practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care

diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in

reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

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Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: **psychotherapy notes;** information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.

Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by discussing with Zoraya Ahumada MD.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our

Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Zoraya Ahumada MD at (346)704-0077 for further information about the complaint process.

This notice was published and becomes effective on 8/1/2018.

Guardian Name _____ Date of Birth_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Zoraya Ahumada MD PLLC effective August 1st 2018.

_____

Relationship/ authority (if signed by authorized representative)

CONSENT FOR TREATMENT

As you know, I share an office with multiple providers. I am an independently practicing professional and share only office space. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no one else can have access to them without your specific, written permission.

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Zoraya Ahumada M.D. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

_____ _____

Signature of Parent, Legal Guardian or Conservator Date Signed

_____ _____

Signature of Witness (if appropriate) Date Signed

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Authorization to Obtain/Disclose Health Care Information

Patient Name _____ Birth Date _____

I request and authorize Zoraya Ahumada MD to release my health care information to and/or to obtain health care information from the following: (please list contact information for your primary care doctor, child's pediatrician, or your or your child's therapist)

Name _____ Phone _____

Address_____

City/State/Zip _____

This request and authorization applies only to the following protected health information:

__ History and Physical __ Laboratory Reports __Consultations __Discharge Summary __ Doctor's Orders

__Progress Notes __ Psychiatric Reports/Tests __Psychology Reports __Psychiatric Assessments

___Neuropsychiatric or psychoeducational testing ___ Psychological testing ____ Verbal Communication

During the following time period or dates: _____

Each disclosure made with the patient's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R Part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom in pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov 2, 1987]

Purpose(s) of this disclosure: continuity of care and collaboration

Authorization expires: _____

I understand that, unless action already has been taken in reliance of this authorization, I may revoke this authorization at any time by making a written request to Zoraya Ahumada MD.

I understand that Dr. Ahumada may not condition treatment, payment, enrollment, or eligibility for benefits on my singing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

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I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

Signature (patient or authorized representative) _____

Date _____

Relationship/authority (if signed by authorized representative):
_____

I would like a copy of this signed authorization: Yes No

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Houston, TX, 77027
(346) 704-0077

Patient Name _____ Date of Birth_____

Telemedicine Consent

Telemedicine isthe use of medical information exchanged from one site to another via electronic Communications to improve patients' health status. Video conferencing, transmission of still images, E-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers areall considered part of telemedicine. The following are included when using telemedicine:

1. I understand that there may be limitations to image quality or other electronic problems that Are beyond the control of the healthcare provider.
2. I understand that there are potential risks of telemedicine encounters including but not limited to:
   - Equipment breakdown (ex: unpredictable power outages)
   - Security and privacy breaches (ex: the use of telemedicine is never 100% secure).
3. I understand that in lieu of this telemedicine encounter, I may seek health care elsewhere Where I might have face-to-face contact with the health care provider.
4. I understand that there are no guarantees with telemedicine.
5. I understand that the telemedicine encounter may be a one-time occurrence and that Treatment and follow-up face-to-face will remain as the preferred method of treatment with Dr. Ahumada.
6. I understand that I must have a face-to-face follow-up appointment at least once a year.
7. I understand I will be charged just as if I were to see Dr.Ahumada in her office, including the no show/cancellation policy.

I certify that I have read and understand the above, including the risks associated with online Medicine, and would still like to proceed with the use of telemedicine.

_____ _____

Patient or legal representative signature Date