CHAMBERS PSYCHIATRIC SERVICES, LLC

Master Practice Packet: Multi-Module Intake, Disclosure & Professional Agreements

MODULE 1: PATIENT INFORMATION & DEMOGRAPHICS

Legal Name:	_____	**DOB:**	_____	**Sex:**	[ ] M [ ] F
SSN:	_____	**Marital:**	[ ] Single [ ] Married [ ] Divorced [ ] Widowed		
Address:	_____				
City, State, Zip:	_____			**Phone:**	_____
Email Address:	_____				
Employer Name:	_____			**Work Ph:**	_____
Referring Phys:	_____	**PCP Name:**	_____		
Emerg. Contact:	_____	**Relationship:**	_____	**Phone:**	

GUARANTOR INFORMATION (IF DIFFERENT FROM PATIENT)

Guarantor Name:	_____	**DOB:**	_____	**Sex:**	[ ] M [ ] F
SSN:	_____	**Phone:**	_____		
Employer Address:	_____				

INSURANCE INFRASTRUCTURE

Primary Insurance Carrier	Secondary Insurance Carrier
Ins. Name: _____	Ins. Name: _____
Member ID: _____	Member ID: _____
Policy Holder: _____	Policy Holder: _____
Holder DOB: _____ SSN (Last 4): _____	Holder DOB: _____ SSN (Last 4): _____

MODULE 2: COMPREHENSIVE CLINICAL, DEVELOPMENTAL & SOCIAL HISTORY

SOCIAL & STRUCTURAL BASELINE

Marital Context:	Years in current dynamic: _____	**Total Marriages:**	_____	**Divorces:**	___
Children?	[ ] No [ ] Yes (List names and current ages): _____			**Reside w/ You?**	[ ] Y [ ] N
Living Setup:	Current environment (e.g., house, apartment): _____			**Family Close?**	[ ] Y [ ] N
Employment:	[ ] Employed [ ] Unemployed [ ] Disabled Job Role: _____ Tenure: _____				
Legal Elements:	History of arrests or convictions? [ ] No [ ] Yes (Check: [ ] DWI [ ] Drug-Related [ ] Domestic [ ] Other)				
Trauma/Abuse:	History of trauma/abuse? [ ] No [ ] Yes (Check: [ ] Physical [ ] Sexual [ ] Verbal [ ] Emotional)				
Support Systems:	Community support programs? [ ] AA [ ] NA [ ] CA [ ] Past [ ] Current Other groups: _____				

CLINICAL & MEDICAL MILESTONES

Physical Exam:	Date of last exam: _____	**EKG Tracking:**	Ever had one? [ ] No [ ] Yes (Date: _____)
Medical History: (Mark **F** for blood relatives)	☐ Asthma/Resp ☐ Cardiac/Heart ☐ Epilepsy/Seizures ☐ GI Pathology ☐ Hypertension ☐ Head Trauma ☐ Liver Disease ☐ HIV / STDs ☐ Diabetes ☐ Thyroid Disease ☐ Pancreas Issues ☐ Abnormal Pap		
Surgical & Hospital:	List past surgeries, significant medical hospitalizations, and approximate dates: _____		
Childhood Core:	Measles: [ ] Yes [ ] No Mumps: [ ] Yes [ ] No Chicken Pox: [ ] Yes [ ] No (Date: _____)		
Family Psych Burden:	Has any biological relative been diagnosed with mental illness? [ ] No [ ] Yes (Detail illness & relation): _____		
Psych Med History:	Have you ever taken psychiatric medications before? [ ] No [ ] Yes (List meds, dates, & why stopped): _____		
Active Prescriptions:	List all current everyday prescription medications & dosing schedules (exclude misused drugs): _____		
Allergies:	List all known allergies to medications, environmental patterns, or food: _____		
Tobacco/Nicotine:	Cigarettes: [ ] Current [ ] Past [ ] Never | Pipe/Vaping: [ ] Current [ ] Past | Packs/Day: _____ for _____ Years		
Substance Rehab:	Have you ever been in clinical detoxification or rehab? [ ] No [ ] Yes (Provide when, where, and duration): _____		

STANDARDIZED SUBSTANCE BASELINE PROFILE MATRIX

Substance Class	Status Profile	Route (Oral/IV/ Smoke)	Avg Quantity & Frequency	Date / Time of Last Use
Alcohol	[ ] No [ ] Past [ ] Now			
Caffeine (Pills/Drinks)	[ ] No [ ] Past [ ] Now			
Cocaine / Crack	[ ] No [ ] Past [ ] Now			
Amphetamines / Meth	[ ] No [ ] Past [ ] Now			
Heroin	[ ] No [ ] Past [ ] Now			
Marijuana / THC / Vapes	[ ] No [ ] Past [ ] Now			
Methadone / Suboxone	[ ] No [ ] Past [ ] Now			
Prescription Pain Killers	[ ] No [ ] Past [ ] Now			
Tranquilizers / Sleep Pills	[ ] No [ ] Past [ ] Now			

Longest Single Period of Clean Abstinence: _____ **Have you ever stopped a drug due to physical dependence?** [ ] No [ ] Yes: _____

MODULE 3: PSYCHOTHERAPY & CORE CLINICAL SERVICES FRAMEWORK

Collaborative Treatment Model: Chambers Psychiatric Services, LLC provides structured psychiatric care incorporating diagnostic evaluations, medical medication management, and integrated supportive psychotherapy. The therapeutic process relies on mutual objective formulation and active patient participation. **Clinical Intent & Risks:** While treatment is systematically targeted at symptom reduction and emotional stability, processing clinical trends can occasionally induce temporary psychological distress, bring up intense memories, or alter personal relationship dynamics.

MODULE 4: STATUTORY TELEHEALTH SERVICES CONSENT (LOUISIANA LAW & CMS COMPLIANT)

Informed Consent Framework: Telehealth involves the electronic delivery of psychiatric and psychotherapeutic care using secure synchronous interactive audio and high-definition video communication. **Patient Rights:** In accordance with Louisiana medical practice acts, Louisiana Medicaid guidelines, and CMS national directives: (1) I reserve the absolute right to withhold or completely withdraw my consent to telehealth interventions at any point during care without compromising my right to future treatment, in-person alternative scheduling, or practice coverage lines. (2) Alternative face-to-face treatment modalities have been detailed and remain subject to scheduling availability. **Mandatory Physical Location Disclosures:** I understand that my provider must be actively licensed to practice medicine in the specific state where I am physically located at the time of the encounter. **I agree to explicitly disclose, verify, and confirm my exact geographic point-of-care location at the immediate onset of every video session.** This information will be explicitly logged alongside the practitioner's physical point-of-origin within the medical chart.

MODULE 5: HIPAA PRIVACY NOTICE & BOUNDARIES OF CONFIDENTIALITY SUMMARY

Your protected health information (PHI) is secured under the federal Health Insurance Portability and Accountability Act (HIPAA) and Louisiana health privacy rules. A full, comprehensive printout of the Notice of Privacy Practices has been provided alongside this packet. Information regarding your clinical care or identity can *only* be disclosed to third parties with your explicit written authorization, with the exception of the following mandatory legal triggers:

1. Reasonable suspicion of physical/emotional abuse, severe neglect, or financial exploitation involving a minor child, elderly individual, or vulnerable adult.
2. Clear, imminent danger where a patient communicates an explicit intent to cause suicide or inflict severe physical harm upon an identified third party (Duty to Protect).
3. Compliance with an enforceable court order, signed judicial warrant, or legally binding statutory subpoena.

MODULE 6: COMPREHENSIVE FINANCIAL POLICY, PRIVATE RATES & ADMINISTRATIVE FEES

Insurance Claims: As an operational courtesy, Chambers Psychiatric Services, LLC may file claims to your participating insurance network. **Insurance coverage is not a guarantee of payment.** Patients maintain direct and absolute financial liability for all copayments, co-insurance percentages, annual deductibles, non-covered administrative services, or any billing balances formally denied or rejected by your insurance provider. The patient is solely responsible for verifying network participation and coverage benefits.

Self-Pay Fee Structure: Patients who do not carry participating insurance, or choose to bypass insurance lines, agree to the following locked rates:

- **Initial Psychiatric Evaluation / Consultation:** $250.00
- **Follow-Up Medication Management / Psychotherapy Visit:** $125.00

Appointment Integrity & Late Cancellations: A scheduled slot sets aside dedicated practitioner time. **Cancellations or rescheduling requests must be communicated at least 24 business hours in advance.** Appointments missed without notice (No-Shows) or canceled inside the 24-hour business window will be automatically assessed a **$50.00 Late Cancellation Fee**. Insurance carriers cannot be billed for missed sessions; this fee is a direct out-of-pocket patient liability. Missing two appointments without notice may result in immediate administrative discharge. Payment is due at the time services are rendered. Chambers Psychiatric Services, LLC maintains a secure credit card on file for automated balance processing.

Administrative Documentation Rate Sheets:

- FMLA / Short-Term Disability Paperwork Review: $100.00
- Emotional Support Animal (ESA) Letter Assessment: $75.00
- Medical Records Copying Requests: Assessed in strict compliance with Louisiana statutory pricing structures.
- Court Appearances, Legal Depositions, Subpoenaed Testimony, & Legal Proceedings: $300.00 – $500.00 per hour (Provider discretion).

Patient / Authorized Representative Signature (Acknowledging Modules 3, 4, 5, and 6)

Date

MODULE 7: CONTROLLED SUBSTANCES & PRESCRIBING REGULATORY AGREEMENT

Controlled medications (such as stimulants, benzodiazepines, or targeted sleep aids) require rigorous clinical oversight. By signing below, I agree to the following terms: (1) I will obtain controlled psychiatric prescriptions exclusively from my designated provider at this practice and utilize a single, authorized pharmacy. (2) I understand the provider queries the Louisiana Prescription Monitoring Program (PDMP) prior to issuing prescriptions. (3) Refills will not be approved early. Stolen, lost, or misplaced medications will **never** be replaced under any clinical circumstance. (4) Random urine drug screens (UDS) and pill counts may be requested. The presence of unprescribed or illicit substances may cause immediate titration and cessation of the medication.

MODULE 8: OPIOID DEPENDENCY TREATMENT CONTRACT (SUBOXONE / BUPRENORPHINE) *IF APPLICABLE*

For patients undergoing medication-assisted treatment for opioid misuse or dependence utilizing buprenorphine products (Suboxone):
1. **Medication Security:** I will take medications exactly as directed sublingually. I agree not to sell, share, or give my medication to another individual. Doing so constitutes a serious federal violation and results in **immediate termination of treatment without appeal**.
2. **Drug Mixing Warning:** Mixing buprenorphine with other central nervous system depressants, **especially benzodiazepines** (e.g., Xanax, Klonopin, Valium) or alcohol, is highly dangerous and increases the risk of respiratory depression, coma, and death. Unapproved concurrent use may result in immediate discontinuation.
3. **Symptom Support:** Medication alone is insufficient; I agree to participate in concurrent counseling as structured in my care plan. I agree to completely abstain from alcohol, unprescribed opioids, cocaine, and all other addictive substances.
4. **Compliance Monitoring:** I will provide random urine samples on request and allow blood alcohol level testing. Missing scheduled maintenance appointments will cause immediate interruption of medication delivery until the next face-to-face visit.

MODULE 9: ADMINISTRATIVE DOCUMENTATION, ESA, & FMLA NO-GUARANTEE FRAMEWORK

Clinical Integrity of Records: Requests for disability paperwork, FMLA tracking, workplace or school accommodations, or Emotional Support Animal (ESA) letters are strictly subject to clinical evaluation and **are never guaranteed**. The provider reserves sole clinical and ethical discretion regarding whether the documentation is justified.

- **FMLA/Disability:** Only considered for patients actively engaged in care for a minimum of **90 days**, backed by objective, documented functional impairment.
- **ESA Letters:** Assessed at an out-of-pocket fee of $75.00 *only* if the provider determines an ESA is a clinically necessary, evidence-based part of the care plan. Payment of the assessment fee does not guarantee a letter will be written.

MODULE 10: DIGITAL SPACES, SOCIAL MEDIA, & PROFESSIONAL BOUNDARIES

To maintain clinical objectivity and protect privacy, practice staff do not accept social networking connection requests (Facebook, Instagram, LinkedIn, etc.) from current or former patients. Do not use public social media platforms or unencrypted text messages to communicate clinical needs. All electronic clinical inquiries must navigate exclusively through the secure, encrypted patient portal.

MODULE 11: FIREARM SAFETY & ENVIRONMENTAL MEANS COUNSELING

Chambers Psychiatric Services, LLC incorporates evidence-based lethal means counseling into safety planning. If a patient experiences severe depressive episodes or acute suicidal ideation, secure environmental engineering is essential. We clinically advise that firearms and ammunition be locked securely, stored completely separate from one another, or temporarily removed from the home by a trusted third party until full clinical stabilization is reached.

MODULE 12: PREGNANCY, LACTATION, & REPRODUCTIVE HEALTH TESTING REQUIREMENTS

Certain psychotropic agents carry significant risk profiles regarding embryogenesis, birth defects, and teratogenic complications.

- **Immediate Notification:** Patients must notify the practice immediately upon discovering a pregnancy or if actively planning a pregnancy.
- **Mandatory Urine Pregnancy Screening:** In alignment with strict safety standards, **this practice requires female patients of childbearing potential to undergo routine, random urine pregnancy testing** during the course of psychiatric medication management, regardless of active sexual status.

Please check one option below to indicate choice:

[ ] I consent to receive pregnancy screenings. [ ] I decline pregnancy screenings. (Reason): _____

Patient / Authorized Representative Signature (Acknowledging Modules 7, 8, 9, 10, 11, and 12) Date

MODULE 13: PEDIATRIC CARE CONSENT & LEGAL CUSTODY MANDATES

This section is mandatory for any patient under the age of 18 or under legal guardianship.

Statutory Authority: Under Louisiana medical statutes, minor children cannot legally consent to elective psychiatric care independent of an authorized adult. **Custody Verification Requirements:** In instances of divorce, legal separation, or state-directed custody, **the presenting parent or legal guardian must provide a certified copy of the finalized custody decree or court order** defining explicit medical decision-making rights *prior* to the initial consultation. If joint legal custody exists with shared medical decision-making authority, both parents should ideally be in agreement. The practice reserves the right to immediately suspend or refuse care if conflicting parental directives emerge.

Minor Patient Name: _____ **Custody Status:** [ ] Parents Married/Together [ ] Sole Custody [ ] Joint Custody (Attached)

MODULE 14: PATIENT RIGHTS & RESPONSIBILITIES

• **Patient Rights:** You have the right to receive safe, respectful, and ethical care free from discrimination. You maintain the right to review your clinical records, receive clear explanations of medication side effects, and actively participate in building your treatment plan.
• **Patient Responsibilities:** You are responsible for providing completely honest, accurate information regarding your health history, symptoms, and substance use. You are required to treat clinic staff with mutual respect, arrive on time for appointments, and satisfy financial balances at the time of care.

MODULE 15: ADMINISTRATIVE TERMINATION & CLINICAL DISCHARGE PROCEDURES

The therapeutic relationship may be dissolved by either party. Chambers Psychiatric Services, LLC reserves the right to administratively discharge a patient from care under the following specific criteria:
1. Continuous non-compliance with prescribed medication boundaries or treatment protocols.
2. Missing two scheduled appointments without giving a 24-business-hour notice (chronic late cancellation/no-shows).
3. Outstanding non-payment of service fees or private pay balances without establishing a financial payment plan.
4. Engaging in hostile, abusive, threatening, or disruptive behavior directed toward practitioners or office personnel.
Discharge Grace Period: If administrative termination is initiated, the patient will receive formal written notification. Chambers Psychiatric Services, LLC will provide emergency psychiatric coverage and medication coordination for a strict window of up to **30 days** from the date of notice to ensure continuity of care while the patient secures an alternative provider.

MODULE 16: COMPREHENSIVE MASTER PACKET ACKNOWLEDGMENT & CONSENT TO TREATMENT

BY SIGNING BELOW, I VERIFY THAT I HAVE READ, FULLY UNDERSTOOD, AND VOLUNTARILY AGREE TO ALL THE POLICIES, PRIVATE FEE SCHEDULES, CONTRACTUAL COVENANTS, AND LEGAL DISCLOSURES OUTLINED ACROSS THIS 5-PAGE COMPREHENSIVE PRACTICE PACKET.

_____ _____

Printed Name of Patient / Legal Guardian **Relationship to Patient (if Minor)**

_____ _____

Signature of Patient or Legal Guardian **Date Signed**

CHAMBERS PSYCHIATRIC SERVICES, LLC

Authorization for the Release or Receipt of Confidential Information

COPY 1: AUTHORIZED EXTERNAL RECIPIENT / PROVIDER

I, _____ (Patient Name), Date of Birth: _____, hereby authorize Chambers Psychiatric Services, LLC to release to and/or receive confidential medical, psychiatric, and behavioral health records from the following external individual, practice, or entity:

Name of Entity / Provider:	_____
Street Address:	_____
City, State, Zip Code:	_____
Phone / Fax Numbers:	**Phone:** _____ **Fax:** _____

SPECIFIC SCOPE OF INFORMATION AUTHORIZED FOR DISCLOSURE (CHECK ALL THAT APPLY):

[ ] Complete Psychiatric Evaluation & Records

[ ] Medication Management Records & History

[ ] Substance Use Disorder Treatment Records

[ ] Psychotherapy Notes & Session Tracks

[ ] Labs, EKG Reports, & Diagnostic Results

[ ] Billing, Financial Ledger, & Claim Forms

Federal Alcohol & Drug Confidentiality Safeguards (42 CFR Part 2): I understand that any released information pertaining to alcohol or drug dependence treatment is strictly protected under federal regulations. The recipient is explicitly prohibited from making any further re-disclosure of this data to third parties without my clear, express written consent. A general authorization for the release of medical records is NOT sufficient for this purpose.

Right to Revoke: I understand that I hold the right to revoke this release authorization at any point in time, either verbally or in writing, except to the extent that the practice has already acted in reliance upon it. This authorization automatically expires 365 days from the date of signature below unless an earlier alternative date/event is defined here: _____.

_____ _____ _____

Patient / Guardian Signature | Date Signed | Witness / Staff Signature

CHAMBERS PSYCHIATRIC SERVICES, LLC

Authorization for the Release or Receipt of Confidential Information

COPY 2: AUTHORIZED EXTERNAL RECIPIENT / PROVIDER

I, _____ (Patient Name), Date of Birth: _____, hereby authorize Chambers Psychiatric Services, LLC to release to and/or receive confidential medical, psychiatric, and behavioral health records from the following external individual, practice, or entity:

Name of Entity / Provider:	_____
Street Address:	_____
City, State, Zip Code:	_____
Phone / Fax Numbers:	**Phone:** _____ **Fax:** _____

SPECIFIC SCOPE OF INFORMATION AUTHORIZED FOR DISCLOSURE (CHECK ALL THAT APPLY):

[ ] Complete Psychiatric Evaluation & Records

[ ] Medication Management Records & History

[ ] Substance Use Disorder Treatment Records

[ ] Psychotherapy Notes & Session Tracks

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_____ _____ _____

Patient / Guardian Signature | Date Signed | Witness / Staff Signature