DALE P. HSIEH MD
Adult Psychiatry
www.doctordale.net

CONSENT AND AUTHORIZATION FOR ELECTRONIC COMMUNICATION (E-MAIL)

E-mail communication provides for a fast and easy way to communicate with your healthcare provider for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of the patient-healthcare provider relationship; rather it can support and strengthen an already established relationship.

General Considerations

- E-mail communications will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- Your e-mail address will never be used for external marketing purposes under any circumstance.
- E-mail sent without encryption has some level of risk that the information in the email could be read by a third party.
- E-mail will be checked TUESDAY THROUGH SATURDAY, once in the morning and once in the evening. Do not expect e-mail responses on Sunday or Monday (emails may be responded too after 8pm on Monday).
- If the office is closed for the holiday or sick day, the email will be checked when the office re-opens.

Provider Responsibilities

- The provider will make every attempt to respond to your email message within 2 business days (most emails responses by me will be done within the day of receiving the email message). If no response is received in 2 business days, please contact the office (512-804-2650).
- Prescription refill requests should not take longer than 2 business days to process. Please note, that not every prescription will be prescribed automatically upon request; some prescriptions may require a face to face appointment. The choice to prescribe medications without an appointment will be made at the discretion of the provider

Patient Responsibilities

- Email messages should NOT be used for emergencies or time sensitive situations. In event of a medical or mental health emergency, you should contact 911 or goto your local emergency room
- E-mail messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via-email

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I have read and understand the above description of the risks and responsibilities associated with electronic communication with my healthcare provider.

I understand that e-mail sent without encryption has some level of risk that the information in the email could be read by a third party and I consent to electronic communication via non-secure email services.

I agree to release Dale P. Hsieh MD from any and all liability that may occur due to electronic communication over a non-secure network.

I have been given the opportunity to discuss electronic communication with my healthcare provider and have had all my questions answered.

I understand that I may revoke my consent to communicate electronically at any time by notifying Dale P. Hsieh MD in writing.

Signature ____________________________________ Date____________

Print Name____________________________________

NEW PATIENT FORM

DALE HSIEH MD
3625 MANCHACA RD #202
AUSTIN, TEXAS 78704

DATE / /

LAST NAME	FIRST NAME	MI	DOB	AGE	☐ MALE ☐ FEMALE

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL	FAX

SOCIAL SECURITY #	EMAIL

EMPLOYER NAME	OCCUPATION	WORK PHONE

BUSINESS ADDRESS	CITY	STATE	ZIP

EMERGENCY CONTACT

	PHONE

ADDRESS	RELATIONSHIP

IF CHILD, PARENT INFORMATION:

MOTHER

LAST NAME	FIRST NAME	DOB	PHONE

EMPLOYER & POSITION	WORK NUMBER

FATHER

LAST NAME	FIRST NAME	DOB	PHONE

EMPLOYER & POSITION	WORK NUMBER

MEDICAL HISTORY

CURRENT CONDITIONS	HOW LONG?

PAST PSYCHIATRIC MEDICATIONS	DOSAGE	CURRENT MEDICATIONS	DOSAGE

ALCOHOL USE?	TOBACCO USE?	ALLERGIES?

PREFERRED PHARMACY NAME	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

PRIMARY CARE PHYSICIAN

NAME	PHONE	FAX

ADDRESS	CITY	STATE	ZIP

I (CIRCLE ONE) DO / DO NOT AUTHORIZE THE MUTUAL EXCHANGE OF INFORMATION BETWEEN DALE P HSIEH MD AND MY/OUR PRIMARY CARE PROVIDER, TO INCLUDE TEST RESULTS, PROGRESS NOTES, AND OTHER MEDICAL INFORMATION. THIS AUTHORIZATION DOES NOT EXPIRE UNLESS NOTED AS FOLLOWS:

X ______________________________ TODAY'S DATE ______________________

PRINTED NAME AND SIGNATURE OF PATIENT (PARENT IF PATIENT IS UNDER 18)

CONTRACT AND CONSENT FOR EVALUATION AND TREATMENT

IN CONSIDERATION FOR RECEIVING MEDICAL, PSYCHIATRIC, AND PSYCHOLOGICAL SERVICE (S), I/WE AGREE TO THE FOLLOWING:

TELEPHONE CALLS

YOUR CALLS ARE WELCOME AND I WILL RETURN THEM PROMPTLY. I CURRENTLY DO NOT HAVE A HIPAA COMPLIANT E-MAIL SERVICE, ALTHOUGH ONE IS PLANNED AT A LATER DATE. THERE IS NO CHARGE FOR BRIEF CALLS. CALLS LASTING MORE THAN FIVE MINUTES WILL BE CHARGED DIRECTLY TO YOU ON A PRO-RATED BASIS, MINIMUM $25. IF YOU HAVE AN EMERGENCY, PLEASE CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM.

PRESCRIPTIONS

TO PREVENT ERROR AND TO MAINTAIN INSURANCE AND HEALTHCARE STANDARDS, WE DO NOT CALL IN ROUTINE PRESCRIPTIONS TO THE PHARMACY AFTER THERE ARE NO MORE REFILLS ON THE PRESCRIPTION. PATIENT MUST BE SEEN IN OFFICE FOR ROUTINE VISITS AND PRESCRIPTIONS. WE MAY CALL IN ONE WEEK SUPPLY OF CERTAIN MEDICATIONS IN EMERGENCY SITUATIONS TO THE PHARMACY. THERE WILL BE $ 25 CHARGE FOR THE CALL IN, BILLABLE TO PATIENT OR GUARANTOR.

HIPAA/PRIVACY ACT

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE BEEN PROVIDED A NOTICE OF YOUR PRIVACY RIGHTS PER HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) REGULATIONS, THE FULL TEXT OF WHICH IS AVAILABLE AT WWW.HHS.QOV/OCR/HIPAA/. YOUR SIGNATURE ALSO ACKNOWLEDGES THAT YOU ARE AWARE OF THE QUALIFICATIONS OF YOUR DOCTORS, THEIR REGULATORY AGENCIES TO WHOM YOU MAY FILE A COMPLAINT, AND GENERAL RULES ABOUT CONFIDENTIALITY AND APPROPRIATE PROFESSIONAL BEHAVIOR.

I HAVE BEEN INFORMED OF AND HAVE READ THE ABOVE INFORMATION AND AGREE TO IT. BY SIGNING THIS CONSENT, I AGREE FOR DALE P HSIEH MD TO PROVIDE ME WITH MEDICAL CARE. I ALSO AGREE FOR LIMITED INFORMATION, IF NECESSARY, TO BE SHARED WITH ANOTHER CLINICIAN IN ORDER FACILITATE MY/MY CHILD'S TREATMENT/EVALUATION.

____
PATIENT'S PRINTED NAME

____
GUARANTOR'S PRINTED NAME

____
PATIENT OR GUARANTOR'S SIGNATURE

____
TODAY'S DATE

RELATIONSHIP OF GUARANTOR TO PATIENT:

- ☐ SELF
- ☐ PARENT
- ☐ GRANDPARENT
- ☐ GUARDIAN
- ☐ SPOUSE
- ☐ OTHER ______________________________

CREDIT CARD AUTHORIZATION FORM

CARDHOLDER NAME (AS APPEARS ON CARD)			
BILLING ADDRESS	CITY	STATE	ZIP
CREDIT CARD TYPE	CARD NUMBER		
EXPIRATION DATE	CVC CODE	CELL NUMBER	

I HEREBY AUTHORIZE DALE HSIEH TO CHARGE AGREED AMOUNTS FOR PRACTICE TO MY CREDIT CARD INFORMATION PROVIDED. I AGREE THAT I WILL PAY FOR THIS PURCHASE IN ACCORDANCE WITH THE ISSUING BANK CARDHOLDER AGREEMENT.

____
CARDHOLDER PRINTED NAME

____
CARDHOLDER SIGNATURE

____
DATE