LA Psychiatry Services

INTAKE FORM

Legal Name: _____

Date of Birth: _____Gender: _____Age: ____ Marital status:_____

Address: _____

City, State, ZIP Code:_____

Home phone: _____ Cell Phone:_____

Other phone: _____ Email: _____

(Mark * next to the best number where we can reach you)

Employed By: _____ Occupation: _____

Business Address: _____

City, State, ZIP Code: _____

Emergency Contact Person (Name/Phone Number):

_____

Insurance Company (if No insurance please write in Private Pay):
_____ **ID#**:_____

Primary Care Doctor (Name/Practice): _____

Phone Number: _____ Fax Number: _____

Referred by: _____ May I thank them: Yes / No

Signature: _____ **Date:** _____

Preferred Pharmacy Address: _____

Phone Number: _____

PAST MEDICAL HISTORY

PAST MEDICATIONS	CURRENT MEDICATIONS
HOSPITALIZATIONS/SURGERIES	
DATE	REASON
MAJOR MEDICAL CONDITIONS (i.e. diabetes, hypertension, head traumas, cardiac problems, asthma, or other breathing problems, cancer, etc.)	
CONDITION	LENGTH OF TIME

PAST PSYCHIATRIC HISTORY (i.e. mental health and chemical dependency)	

FAMILY MENTAL HEALTH & CHEMICAL DEPENDENCY HISTORY

ALLERGIES:_____

YOUR SUBSTANCE ABUSE HISTORY (COMPLETE FOR ALL PATIENTS 13 AND OVER)				
SUBSTANCE	**AMOUNT**	**DURATION**	**FIRST USE**	**LAST USE**
CAFFEINE				
TOBACCO				
ALCOHOL				
MARIJUANA				
OPIOIDS/ NARCOTICS				
AMPHETAMINES				
COCAINE				
HALLUCINOGENS				
OTHERS				

LA Psychiatry Services

AUTHORIZATION FOR RELEASE OF INFORMATION (OPTIONAL)

Print Name of Client **Date of Birth**

If client is a minor:

_____

Print Name of Parent/Guardian Date of Birth

I hereby authorize **LA Psychiatry**, to exchange information with:
Name of Agency/Person/Organization: _____
Address:_____
City, State, ZIP Code: _____
Phone #: _____ **Fax #:** _____
With the knowledge that such contact discloses the fact that mental health services have been/are being provided.
This disclosure of information is required for the following purpose(s):

□ Evaluation □ Treatment Planning/Course □ Other_____
And will consist of the following types of information:
□ Entire Record □ Medication History □ Discharge Summary □ Legal Information
□ Dates / Results of Medical Assessments & Diagnoses
□ Results of Psychological Testing
□ Educational Information □ Other _____

The information and records released pursuant to this consent will not be used for any other purpose.
This consent becomes effective immediately. This consent may be revoked by the undersigned at any time. I understand that I may receive a copy of this authorization. There is a risk that the person receiving information or documents pursuant to this authorization may re-disclose the information and documents in a manner that will no longer provide protection for the information and documents.

_____**Date:** _____ **Signature**

☐ All requests for release of information must be in writing. If there are any parties to which you do not want to release this information. Please complete a Request for Special Privacy Protection (HF 04a).

LA Psychiatry Services

CONSENT FOR TREATMENT

I hereby authorize and request **LA Psychiatry, Professional Corporation,** to carry out psychiatric and psychological examination, evaluation, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that these are subject to my agreement. I fully understand that while the course of my treatment is designed to be helpful, **LA Psychiatry, Professional Corporation,** can make no guarantees whatsoever about the outcome of my treatment. I also understand that the psychopharmacotherapeutic process can initiate and bring up uncomfortable feelings and reactions including, but not limited to anxiety, sadness, anger and physical side effects. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be jointly worked on between my therapist and me.

Patient Signature:

_____

Date

CONSENT TO TREATMENT IN CASE OF DEPENDENT/CHILD/MINOR

I am the legal guardian and/or representative of the patient and on the patient's, behalf legally authorize **LA Psychiatry, Professional Corporation,** to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Signature of Guardian/Legal Representative:

_____

Date

LA Psychiatry Services

HIPPA NOTICE OF PRIVACY PRACTICES

A federal law, known as the "HIPAA Privacy Rule" requires that we tell you how we may use and give out personal health information about you to others. This summary will tell you what our Privacy Notice contains.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION
We may use and share personal health information that is protected (PHI) to you or your personal representative. We may use and share this information:

For healthcare treatment that doctors, nurses and other clinicians give you for certain business activities called "health care operations" and
For payment.

Some examples of how we may use and share PHI about you without your written permission including sharing information:

To report abuse, neglect, or domestic violence
To prevent a serious threat to your other's health or safety
To prevent public health problems
To agencies that audit, investigate and inspect health programs for the public's health For lawsuits and other legal proceedings
For research
To the Government for specialized purposes, such as military or national security; and For worker's compensation.

YOUR RIGHTS
You have the following rights as described in our Notice:

The right to ask us if we will put more limits on the way we use and share PHI about you The right to share confidential communications from us
The right to see and get a copy of PHI about you
The right to ask us for a report that describes how and with whom we share PHI about you.

If you have any questions regarding your rights or privacy, please inquire with our office or reference http://www.hhs.gov/ocr/privacy.

I hereby acknowledge that I have read a copy of this HIPAA Notice of Privacy Practices. I further acknowledge that I may obtain a copy if requested.

PATIENT (PRINT): _____
SIGNATURE: _____ DATE:_____

IF PATIENT IS UNDER THE AGE OF 18:
RESPONSIBLE PARTY (PRINT): _____
RELATIONSHIP TO PATIENT: _____
SIGNATURE:_____DATE:_____

LA Psychiatry Services

OFFICE POLICIES

Confidentiality:

Confidentiality is essential for effective psychiatric treatment. No information will be released without your consent, except for the following situations: By law, I am required to report suspected child or elder abuse, domestic violence, and take action when a patient is considered to be danger to themselves or other.

Payment Policy:

Scheduled appointment times are reserved specifically for you. Failure to provide 24 hours cancellation notice or missed appointments will be charged. Missed appointment fee is $50.00.

Private Pay Patients: Patients are required to pay full amount on day of visit unless otherwise advised by the Doctor.

Medication Policy:

You are responsible to make an appointment to see me in person at least once every 2 months to receive refills on your medications. If you are taking a controlled substance you are responsible to make an appointment every month in order to receive a refill unless otherwise stated by the Doctor.

Requests for refills may take up to 48 hours to be available at your pharmacy and are not done on weekends or holidays.

Notify LA Psychiatry of any side effects of your medication.

Notify LA Psychiatry if you suspect or know that you are pregnant or if you plan to become pregnant in the near future.

Notify LA Psychiatry any time another physician starts you on a new medication, or if there are significant changes in your psychiatric or medical condition.

By law, under any circumstances, we are not allowed to offer a refill for a controlled substance under the 30-day supply cycle.

Additional Services:

Services required outside of treatment session will be charged a fee. These will include consultations with other professionals, court appearances, disability forms (including approval), and document preparation such as completing legal forms, conservatorship petitions, letters, etc. For any type Disability/FMLA/EDD Forms we require at least 3 months of treatment in order to evaluate the need for approval.

I have read, understand and agree to the above policies.

Patient Name: _____

Signature of Patient/Guardian (if patient is a minor):_____ **Date:** _____

LA Psychiatry Services

PATIENT ARBITRATION AGREEMENT

The contract below is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather that a suit in court. I believe the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts. By signing this agreement, you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings. Of course, my goal is to provide medical care in such a way as to avoid any such disputes. I know that most problems begin with communication. Therefore, if you have any questions about your care, please ask me.

By signing this agreement, the patient agrees with the provider that any dispute between you and LA Psychiatry Services and any dispute relating to medical services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whomever made (including, to the full extent permitted by applicable law, third parties who are not signatories to this agreement) shall be resolved by binding arbitration. Any award of the arbitrator(s) may be entered as a judgment in any court having jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective and the remainder of the agreement shall remain effective. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

This agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children. This provision for arbitration may be revoked by written notice delivered to the physician within 30 days of signature.

If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the physician, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

Patient Name _____

Signature of Patient or Responsible Party (if Patient is a Minor) **Date**

LA Psychiatry Services

Informed Consent for Telepsychiatry/Telehealth Services (OPTIONAL)

Date: _____ Patient Name: _____

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand that the laws that protect the privacy and the confidentiality of patient medical information also apply to telehealth services which may include general medicine and behavioral health.

As always, my insurance carrier will have access to medical records for quality review/audits**. I understand that I will be responsible for any copayments or coinsurance that may apply to my telehealth visit**. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may also revoke my consent orally or in writing at any time by contacting LA Psychiatry Services.

TELEPSYCHIATRY: I have been given information regarding the use of Telepsychiatry/ Telehealth and consent to participate in services utilizing this technology. If I am under the age of 18, such information was shared with and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in telepsychiatry services, in which case evaluations will be conducted in-person by appropriate clinicians. I understand that telepsychiatry services may reduce any delays in services, need to travel or other risks associated with not having the services provided by telepsychiatry/telehealth services. Furthermore, I am made aware that each telepsychiatry/telehealth session shall not be recorded without my consent.

I agree to participate in telepsychiatry/telehealth services.

Signature of patient _____ Date: _____
(Or person authorized to sign for patient):
_____ Date: _____

IF YOU SIGN TO DO TELEPSYCH, YOU ARE REQUIRED TO PROVIDE A CARD ON FILE:

Debit/Credit Card Number: _____
Zip Code: _____ 3 Digit Code: _____
Expiration Date: _____