☐ Corona

☐ Rancho C.

CHOICE
PSYCHIATRIC MEDICAL GROUP

☐ Murrieta

PATIENT INFORMATION

PATIENT NAME: _____ _____ _____ D.O.B. _____/_____/_____
FIRST LAST MI MM / DD / YYYY

GENDER: ❑M ❑F SOCIAL SECURITY NO. _____-_____-_____ CA. DRIVING LIC. _____EXP _____

TELEPHONE: CELL #_____ HOME #_____ LANGUAGE _____
*(MARK THE PREFERRED CONTACT NUMBER WITH STAR *)*

E-MAIL ADDRESS: _____

ADDRESS _____ _____ _____ _____
MAY SEND MAIL ☐Yes ☐No STREET CITY STATE ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ ID _____

PRIMARY SUBSCRIBER: _____ ❑ Self ❑ Spouse ❑ Parent ❑ Other _____

D.O.B.: _____ GROUP #: _____ C.D.L.#: _____ Exp: _____ TEL. #: _____

ADDRESS _____ _____ _____ _____
STREET CITY STATE ZIP

EMPLOYER'S NAME: _____

SECONDARY INSURANCE NAME: _____ ID _____

SECONDARY SUBSCRIBER: _____ ❑ Self ❑ Spouse ❑ Parent ❑ Other _____

D.O.B.: _____ GROUP #: _____ C.D.L.#: _____ Exp: _____ TEL. #: _____

ADDRESS _____ _____ _____ _____
STREET CITY STATE ZIP

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE#: _____
ADDRESS: _____

PRIMARY CARE / PHARMACY

Primary Care Physician: _____Contact #:_____Fax#:_____

Mailing Address: _____City _____ State ____ Zip _____

Pharmacy Name: _____Pharmacy Tel #: _____

Pharmacy Address _____ City _____State ____ Zip _____

Referring Physician_____

X _____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____
PRINT NAME / Relationship

PLEASE TURN PAGE

PATIENT NAME:_____ DATE OF BIRTH:_____

FOR MINORS ONLY

Mother's Name: _____ Home phone: _____ Cell phone: _____

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

Father's Name: _____ Home phone: _____ Cell phone: _____

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

Child Lives With (circle one): Mother / Father / Both / Grandparent / Guardian / Foster Parent / Ward of State

Guarantor's Name: _____ DOB: _____ Social Security #: _____

Address _____

Relationship to Minor _____ Home phone: _____ Cell phone: _____

School : _____ Grade: _____

CHILD & ADOLESCENTS

Development History (i.e. development milestones met early, late, normal):

Peri-Natal History (i.e. details of labor/delivery):

Pre-Natal History (i.e. medical problems during pregnancy, mother's use of medications):

Prenatal care starting at what month? _____ Any bleeding? _____ High blood pressure? _____ Anemia? _____

Nutrition: Adequate? _____ Inadequate? _____

Smoking? _____ If yes, how much? _____ Drinking? _____ If yes, how much? _____

Drugs – Prescribed? ____ Name? _____ Non-Prescribed? ____ Name? _____

Delivery: At what month of pregnancy? _____ Was labor induced? _____ Duration in hours? _____

Condition of infant immediately after birth, and during first month:

_____

_____

_____

PATIENT NAME:_____ DATE OF BIRTH:_____

LIST TOP 3 REASONS FOR THIS VISIT

1)_____ 2) _____ 3) _____

Are you experiencing any of the following:

- ❑ Depressed mood
- ❑ Crying spells
- ❑ Lack of interest in activities
- ❑ Increased appetite – weight gain
- ❑ Loss of appetite - weight loss
- ❑ Suicidal thoughts
- ❑ Panic attacks
- ❑ Worrying about many things,
- ❑ Sweaty palms – Fatigue
- ❑ Heart racing – inability to relax
- ❑ Rapid breathing – Muscle tension
- ❑ Difficulty breathing at times
- ❑ Difficulty concentrating.
- ❑ Difficulty maintaining attention.
- ❑ Decreased need to sleep
- ❑ Thoughts running too fast
- ❑ Talk too much
- ❑ Irritable mood
- ❑ Hearing voices
- ❑ Seeing things which are not there.
- ❑ Feel like someone is watching
- ❑ Cameras monitoring me
- ❑ People are after me
- ❑ Agitation
- ❑ Confused – disturbed thoughts
- ❑ Thoughts to hurt others.
- ❑ Snoring – Tired all day - fatigue
- ❑ Difficulty falling asleep
- ❑ Difficulty maintaining sleep
- ❑ Headaches
- ❑ Sleeping too much
- ❑ Nightmares
- ❑ Sleep walking
- ❑ Confusional arousals
- ❑ Bedwetting
- ❑ Teeth grinding
- ❑ Daytime sleepiness
- ❑ Obsession with continuous exercise.
- ❑ Use or hiding use of diet pills, laxatives
- ❑ Obsession with weigh
- ❑ Binging and/or purging.
- ❑ Pre-occupied thoughts of food, weight
- ❑ Loss of menstrual cycle
- ❑ Emotional roller coaster
- ❑ Fear of abandonment
- ❑ Unstable or Trouble with relationships
- ❑ Low self esteem
- ❑ Rapid changes in self-identity, self-image
- ❑ Impulsive or risky behavior.
- ❑ Mood swings.
- ❑ Feelings of emptiness

MEDICAL HISTORY

List any medical conditions you have been treated for: _____

_____

_____

List any Surgeries you had with date: _____

Head Trauma ❑ No ❑ Yes. If yes, please explain _____

Current Medications: *List any Medications and supplements you are currently taking and include dosage & frequency:*

_____ _____

_____ _____

Allergies: ❑ No ❑ Yes. Include medications, food or other products: _____

PAST PSYCHIATRIC HISTORY

When was the first time you were evaluated by a Psychiatrist or Therapist? _____

History of Physical or Sexual abuse: ❑ No ❑ Yes _____

PAST PSYCHIATRIC MEDICATIONS:

_____ _____

_____ _____

Hospitalizations: _____

Have you ever attempted to harm/kill yourself? ❑ No ❑ Yes. If yes, please list the occurrences below:

Approximate date of attempt: _____ How did you attempt (method)? _____

Approximate date of attempt: _____ How did you attempt (method)? _____

PATIENT NAME:_____ DATE OF BIRTH:_____

SUBSTANCE ABUSE: ❑ Alcohol ☐ Current ☐ Former ☐ Never

If current, Have you ever felt you should cut down your drinking? ☐Yes ☐No Taken a drink first thing in the morning as an eye opener? ☐Yes ☐No
Have people annoyed you by criticizing your drinking? ☐Yes ☐No Have you ever felt bad or guilty about your drinking? ☐Yes ☐No

❑ Cannabis ❑ Ecstasy ❑ Cocaine ❑ Methamphetamine ❑ LSD ❑ PCP
❑ Heroine ❑ Pain Meds ❑ Mushrooms ❑ Sherm ❑ Glue ❑ Paint

FAMILY HISTORY:

Medical/Psychiatric Condition: _____ Relationship: _____

_____ Relationship: _____

SOCIAL HISTORY: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow ❑ Common law

Sexual Orientation: ❑ Heterosexual ❑ Gay ❑ Lesbian ❑ Bisexual ❑ Transgender – Female-to-male, Male-to-female.

Born and raised in: _____ Adopted: _____ Religion: _____

Brothers _____ Sisters _____ Living with: _____

Children: (ages & sex)_____

Education: _____ Hx of Special Education: _____ Work History: _____

LEGAL HISTORY: Have you been in ❑ Juvenile Hall ❑ Jail ❑ Prison. Explain _____

ANY OTHER INFORMATION THAT MAY BE HELPFUL IN YOUR TREATMENT:

_____

_____

PATIENT RELEASE

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agents, for purpose of filing and payment of medical claims.

I understand that if I am using insurance for treatment, I directly assign my insurance benefits to my provider.

I hereby authorize the use of this signature on all insurance submissions on my behalf. I understand in the event that payment is not submitted directly to CPMG, it is my responsibility to submit any payment I receive for services rendered by CPMG, directly to this office.

EXTERNAL PRESCRIPTION HISTORY CONSENT:

I authorize CPMG to view my external prescription history via the electronic health record systems, I understand that prescription history from multiple other medical providers, insurance companies, and pharmacies may be viewable by my providers and authorized staff here, and it may include prescriptions from previous years.

CONSENT TO TREAT:

I give consent to my physician to provide the medical/psychiatric care, perform tests, prescription of medications and other services that are considered necessary or beneficial for me or my child's health and wellbeing. I acknowledge that no representations, warranties or guarantees related to results or cures have been made to me or relied upon by me.

Your signature below indicates that you have read this agreement and agree to abide by its terms. You have the right to revoke this agreement in writing at any time.

X _____ _____

Signature of Patient, Legal Guardian/Legal Representative | Printed Name / Relationship to patient | Date

_____

Patient Name (if different from that above)

PATIENT NAME:_____ DATE OF BIRTH:_____

CONSENT FOR TREATMENT

I hereby authorize and request Choice Psychiatric Medical Group 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, Choice Psychiatric Medical Group 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/Guardian Signature:

X _____ Date _____

GENERAL 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 Choice Psychiatric Medical Group 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:

X _____ Date _____

Relationship to Patient: _____

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

• You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office in writing.
• If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
• You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
• You have a right to a copy of this signed authorization.
• If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire twelve months from the date of signature. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in HIPAA. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Department.

Disclosure may include the following verbal or written information:

Laboratory/diagnostic testing results	Behavioral health/psychological consult
Medication records	Psychiatric evaluation
Psychosocial assessment	Summary of treatment records & contact dates
Substance abuse treatment record	Other

Choice Psychiatric Medical Group is authorized to release protected health information related to the evaluation and treatment of the above named patient.

X _____ _____

Patient / Guardian Signature Date

☐ _____ I hereby refuse to give authorization for any release of information _____

Signature

FINANCIAL POLICY

Thank you for choosing Choice Psychaitric Medical Group (CPMG) as your mental health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for service is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to your treatment.

PATIENT INFORMATION:
A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly and will include where the patient can be reached by phone. A signature by the responsible party is required.

INSURANCE CLAIMS:
We will file claims with the patient's primary insurance upon the patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at the time of service. Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

PATIENT FINANCIAL RESPONSIBILITY:
If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, **full payment is expected.** Co-payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, checks and credit cards. First visit is charged $450.00 and subsequent visits are $250.00 for 15-20 min sessions.

PAST DUE ACCOUNTS:
Any outstanding balance, after insurance has paid, will be invoiced to you on a statement. Payment is due upon receipt of the statement. Prolonged delinquency in payment will result in preparation of account to be sent to a collection agency. This may result in a discharge from the practice.

METHOD OF PAYMENT:
Acceptable methods of payment are cash, check, VISA, MasterCard and Discover. Credit cards payments can also be accepted by phone or fax. There will be a $50.00 fee for returned checks. Please provide a valid credit card for any charges.

❑ MasterCard ❑ Visa ❑ AMEX ❑ Discover

Credit Card Number _____ Exp. Date 23/2019_____ CCV #23213_____ Billing Zip Code _____

CANCELLATION/NO SHOW/RESCHEDULE POLICY:
It is essential you are on-time for your appointment and call at least 24 hours in advance when you are unable to keep your scheduled appointment. Failure to show up for your appointment or cancel without 24 hours notice will result in a $65.00 charge.

RECORDS:
Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or patient's parents) release of information form. Record are sent at a fee of $25 including postage and billed directly to you. Please allow two weeks for this request to be processed for each request.

MINORS/DEPENDENTS:
Children under the age of 18 will require the signature of a responsible party on the registration form. The adults accompanying a minor and the parents or guardians are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment plan or payment by cash or check at time of service has been verified.

Authorization To Pay Benefits To Provider
I hereby authorize payment directly to the Provider of service for mental health benefits, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services.

ACKNOWLEDGEMENT OF RECEIPT:
I have reviewed the financial policy, and I accept financial responsibility of collection.

MISCELLANEOUS FEES:	
$25-$50 Medical Records	$25 Letter writing
$10 per page for all forms	$50 for disability paperwork
$65 Cancellation/ No Show	$1,000 Court Appearances

X _____ _____ _____

Signature of Patient, Legal Guardian/Legal Representative | Printed Name / Relationship to patient | Date

_____

Patient Name (if different from that above)

PLEASE TURN PAGE

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. We 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, our goal is to provide medical care in such a way as to avoid any such disputes. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

By signing this agreement, the patient agrees with the provider that any dispute between you and Choice Psychiatric Medical Group 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 _____ Patient/Responsible Party Initials: _____

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: _____

X _____ _____

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

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient or Subscriber Name: _____
(Please print patient or subscriber name)

I, _____ ,
(Print name of patient, subscriber, conservator, parent or legal guardian signing below)

acknowledge receipt of the Notice of Privacy Practices, which explains limits on ways in which the clinic may use or disclose personal health information to provide service, provided by: Choice Psychiatric Medical Group

Signed: X _____ Date: _____

Relationship to Patient _____

DO NOT WRITE BELOW THIS LINE

**** THIS SECTION TO BE FILLED BY STAFF ONLY ****

Patient **DID** receive the Notice of Privacy Practices, but did not sign this Acknowledgment of Receipt because:

- ❑ Patient left office before Acknowledgment could be signed.
- ❑ Patient does not wish to sign this form.
- ❑ Patient cannot sign this form because: _____

Patient **DID NOT** receive the Notice of Privacy Practices because:

- ❑ Patient required emergency treatment.
- ❑ Patient declined the Notice and signing this Acknowledgment.
- ❑ Other: _____

Name: _____
(Print name of provider or provider's representative)

Signed: _____ Date: _____
(Signature of provider or provider's representative) *HIPPA-1a (with acknowledgement)*