San Marino Psychiatric Associates
A Medical Group

Office Use Only:

Provider: _____

Acct #_____

Date: _____

New Patient Form

Name_____ DOB:_____ M ☐ F ☐

*If Patient is under 18, please answer the following questions: Are parents married or divorced?*_____

*If divorced, who has legal custody?*_____ *Who has physical custody?*_____

Mailing Address:_____

City_____State_____Zip:_____

To respect your privacy, please indicate which of the following numbers we should call to communicate with you. We may also call you for Appointment Reminders, Lab Results, etc. Only list the phone number, or phone numbers, you want us to call and leave messages.

Home: ( )_____Cell: ( )_____Work: ( )_____

SS#_____DL:_____Mother's Maiden Name:_____

Responsible Party

Responsible Person (*if other than patient*)_____

Mailing Address:_____

Primary and/or Secondary Insurance

Insured's Name:_____SS#_____

Relationship to Patient:_____Insured's DOB:_____

Name of Insurance:_____Policy #_____

I.D. or Plan #_____Phone #_____

Claim Address:_____

Insured's Employer and Address:_____

Secondary Insurance:_____Insured's I.D._____

Secondary Insurance Phone #_____Policy or Group#_____

Preferred Pharmacy

Pharmacy Name_____Phone # ( )_____

Mailing Address:_____

Emergency Contact Information

Contact:_____Relationship:_____Phone # ( )_____

Nearest relative or friend (*other than spouse or parent*):_____Phone # ( )_____

SAN MARINO PSYCHIATRIC ASSOCIATES
2400 MISSION STREET
SAN MARINO, CA 91108
(626) 403-8999

MENTAL HEALTH DISCLOSURE FORMS

Financial Terms: Insurance Coverage and Copayments ☐ N/A

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance, however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility.

At any time during treatment should I become ineligible for insurance coverage, I will notify the practitioner and understand I will become responsible for 100% of the bill.
Initial here: _____

Assignment of Benefits ☐ N/A

I authorize my insurance carrier to directly pay my practitioner. **Initial here:**_____

Payment and Billing

It is our policy that payment for services is due when services are rendered.

1) Patients will receive a monthly statement itemizing previous balance, current charges, payments and balance due.
2) Account balances over 90 days will be charged an additional 1% a month.
3) Accounts with balance due over 90 days, and no current payment history are subject to be referred to a collections agency. Patients will be given notice of delinquent account with an opportunity to make payment and arrange a payment schedule prior to collections agency action.

I understand the payment policy and the above billing policies 1, 2, and 3. **Initial here:** _____

Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 business hours notice, the patient will be billed according to our scheduled fee.
Initial here: _____

Limits of Confidentiality Statement

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson v County of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff v. Regents of University of California, 1967).
5. Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions. **Initial here:** _____

Release of Information
I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.
Initial here: _____

Urgent Access
A covering practitioner is available after hours to handle urgent matters.. By calling the main office number during after hours, you will be instructed how to contact the on-call practitioner. For emergencies: call 911 or go to the nearest hospital. **Initial here:** _____

Controlled Prescriptions (RX) We require 3 business days to complete a Controlled prescription request. The Doctor needs to review your medical record before writing a Controlled prescription. There is **a $30 charge** for all Controlled Prescriptions that are requested outside of a regular scheduled appointment. Please note that any Controlled RX written by an On-call Doctor during your Doctor's absence can take longer to review.
Initial here: _____

Consent for Treatment
I authorize and request my practitioner to carry out psychological and/or psychiatric exams, 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 they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.
Initial here: _____

_____ _____
Patient/Guardian Signature Date

_____ _____
Practitioner/Witness Signature as needed Date

General Consent for Child or Dependent Treatment
I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner/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.

_____ _____
Patien

t Name Patient's DOB

_____ _____ _____
Signature of Legal Guardian/Legal Representative Relations to Patient Date

MEDICAL HISTORY FORM

Patient's Name_____ **Date**_____

Please describe your reason for seeking our services at this time. When did the problem start?

_____

_____

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	no effect	little effect	some effect	much effect	not applicable
Marriage/Relationship	1	2	3	4	N/A
Family	1	2	3	4	N/A
Job/School performance	1	2	3	4	N/A
Friendships	1	2	3	4	N/A
Hobbies	1	2	3	4	N/A
Financial situation	1	2	3	4	N/A
Physical health	1	2	3	4	N/A
Anxiety level/Nerves	1	2	3	4	N/A
Mood	1	2	3	4	N/A
Eating habits	1	2	3	4	N/A

If your eating habits are affected, describe how: _____

_____

Sleeping habits. If you sleeping habits are affected, describe how: _____

_____

Sexual functioning	1	2	3	4	N/A
Ability to concentrate	1	2	3	4	N/A
Ability to control temper	1	2	3	4	N/A
Spirituality	1	2	3	4	N/A

PERSONAL MEDICAL HISTORY

1. Please provide the following information:
   Name of personal physician_____ Phone ( )_____
   Address_____ Zip Code _____
2. When was your last physical examination? _____ What were the results? _____

   _____
3. Have you ever had any of the following illnesses?

	No	Yes		No	Yes
High blood pressure	☐	☐	Migraine headaches	☐	☐
Diabetes	☐	☐	Stomach ulcers	☐	☐
Cancer	☐	☐	Colitis	☐	☐
Thyroid disease	☐	☐	Meningitis/encephalitis	☐	☐
Other hormone problems	☐	☐	Tuberculosis	☐	☐
Alcoholism/drug abuse	☐	☐	Stroke	☐	☐
Glaucoma	☐	☐	Rheumatic fever	☐	☐
Epilepsy	☐	☐	Asthma	☐	☐
Birth defects	☐	☐	Head injury	☐	☐
Arthritis	☐	☐	Sexually transmitted diseases	☐	☐
Heart problems	☐	☐			

Have you had any other diseases? Is so please explain_____

_____

4. Have you ever had any serious injuries_____If so, please explain_____

_____

5. Please list all prescription medications and over the counter medications you currently use (name, dosage, frequency)

_____

_____

6. Please list any allergies _____
7. Review of your Personal Psychiatric History

Have you ever received any psychiatric or psychological treatments?_____If so please indicate:
Outpatient psychotherapy_____
Group psychotherapy_____
Hospitalization_____
Medication_____

8. Review of your CURRENT Health (within the past year)

	No	Yes		No	Yes
Lumps anywhere	☐	☐	Palpitations	☐	☐
Visual disturbance	☐	☐	Swelling/hands, feet	☐	☐
Difficulty hearing	☐	☐	Vomiting, vomiting blood	☐	☐
Fainting/blackouts	☐	☐	Excessive thirst	☐	☐
Convulsions	☐	☐	Urinary problems	☐	☐
Paralysis	☐	☐	Indigestion/gas/heartburn	☐	☐
Dizziness	☐	☐	Stomach ulcer/pain	☐	☐
Headaches	☐	☐	Diarrhea	☐	☐
Constipation	☐	☐	Thyroid problems	☐	☐
Skin problems	☐	☐	Blood in stool	☐	☐
Cough or wheeze	☐	☐	Eating/appetite changes	☐	☐
Chest pain	☐	☐	Trouble sleeping	☐	☐
Spitting up blood	☐	☐	Weight loss/gain	☐	☐
Sexual problems	☐	☐	Anxiety	☐	☐
Joint pain	☐	☐	Shortness of breath	☐	☐
Depression	☐	☐	Hallucinations	☐	☐
Weakness/tiredness	☐	☐	Memory/thinking/ Concentration problems	☐	☐

Please describe or explain any of the "yes" answers prior:_____

_____

9. What is your current height?_____ Current weight?_____
What is the most you have ever weighed?_____ When?_____
What is the least you have ever weighed?_____ When?_____

10. Habits

	Amount currently using	Most ever used
Coffee (cups/day)		
Cigarettes (pack/day)		
Alcohol/Drugs		

11. Family Medical History

a) Has anyone in your family had a serious medical illness? If so, please explain_____

b) Has anyone in your family had a psychiatric (nervous or mental) illness? Is so, please explain_____

c) Has anyone in your family had a substance abuse (alcohol or drugs) problem? If so, please explain_____

12. **FOR FEMALES ONLY**

A. Date your last menstrual period began_____Number of pregnancies_____
Number of children born alive_____Number of therapeutic abortions_____
Number of miscarriages or stillbirths_____
Have you had a Pap smear within the last year?_____Is so, what were the results?_____
Do you use any contraceptive method?_____What?_____
Do you examine your breast for lumps? _____
Do you have menstrual cramps? _____ ☐ Mild ☐ Moderate ☐ Severe

PREMENSTRUAL SCREENING QUESTIONS

B. Have you noticed any particular mood change during some part of your menstrual cycle?

Yes ☐ No ☐

If yes, what part(s) of the cycle?

Menses ☐ Middle of cycle ☐ Premenstrual ☐

Are the changes: Mild ☐ Moderate ☐ Severe ☐

Do you presently take birth control pills? Yes ☐ No ☐

If yes, what kind?_____

FOR CLIENTS UNDER 18 YEARS OF AGE

SCHOOL AND AGENCY INFORMATION

1. Did child attend pre-school? Yes___ No___ Beginning at what age?_____
   Describe any problems_____
   _____
2. Name of current teacher_____
3. Describe any behavioral problems now in school_____
   _____
4. Describe any learning problems in school_____
   _____
   If the child has ever been kept back or put ahead in school, explain:_____
   _____
   If the child has been in special classes, list ages, reasons?_____
   _____
5. If the child has ever been excluded from school, explain when and why:_____
   _____
6. If the child is on probation, who is the Probation Officer?
   Name_____ Phone_____
   Are any other agencies involved with the family? (DPSS, Child Welfare, etc.)
   _____

CHILD'S DEVELOPMENTAL HISTORY

Period During Pregnancy

Was the child planned?_____ Sex Preference_____

How did the mother feel about having the child?_____

Did the mother have any medical or emotional problems during pregnancy (For example: Convulsions, hemorrhages, infection, unusual nervousness):

_____

_____

How did father feel about having this child?_____ Sex Preference _____

Did mother work during pregnancy? _____ How long? _____

Details of Delivery, Questions about Labor

Were there any complications of labor and delivery? Describe_____

_____

_____

Did the mother have any "Blues" after baby's birth?_____

Postnatal

1. Weight of baby at birth?_____ Was the baby full term? (9 months) Yes___ No___

Were there any complications after the baby was born? (For example, difficulty breathing, baby cyanotic (blue), R.H.Factor, baby jaundice.)_____

_____

2. Was child separated from either parent or other significant caregiver for longer than one week?_____ When_____
3. If adopted, at what age was child placed in your home? _____

   Is information available about the birthparents? _____
4. Did the mother have any help in home after delivery? Yes_____ No_____

   If yes, how long?_____

   During the baby's first year of life, was there anything (even if it had nothing to do with the baby) that caused the mother unhappiness or anxiety or that placed her under special strain? Yes_____ No_____

   Describe_____

   _____

   After baby's birth, how soon did mother return to work?_____

   If mother was working, who had primary caretaking responsibility?_____
5. Was the child ever separated from both parents? Yes_____ No_____

   Describe the circumstances (reason, child's age at time, and how long?)_____

   _____

   _____
6. Did the father take an active part in the baby's care (such as changing diapers, bathing, feeding, etc.)? Yes____ No____

FEEDING

1. Breast fed_____ How long_____ Bottle fed_____ How long_____
2. Were there any feeding problems (colic, diarrhea, or food allergies)? Yes_____ No_____

   If so, explain_____

   _____

   _____
3. When was the child weaned?_____ Why did the weaning occur at time?_____

   _____

   _____
4. How was child's discomfort handled?_____

   Any thumb-sucking?_____ Describe_____

   _____

SLEEPING PATTERNS

1. Were there sleeping problems?_____ Describe_____

   _____
2. Has the child ever slept with the parents? Yes_____ No_____

   Describe circumstances_____

   _____
3. Present sleeping arrangements_____

   _____

MOTOR DEVELOPMENT

1. Was your child ever too active or too quiet?_____ Please describe_____

   _____

2. At what age did your child start: Sitting_____ Standing_____ Walking_____

3. Who took primary responsibility for toilet training?_____

   At what age was bowel training begun?_____ Completed?_____

   Method used_____

   At what age was bladder training begun?_____ Completed for day?_____

   Completed for night?_____ Method used_____

   _____

   Was your child's toilet training ever a problem?_____

   How?_____

   _____

   Is this a problem at present?_____ Describe_____

   _____

4. Is your child primarily right-handed?_____ Left-handed?_____

5. Describe any speech difficulties?_____

   _____

SEXUAL DEVELOPMENT

1. Has your child expressed curiosity about any sexual matters to a parent?_____ About what?_____

   _____

2. Has your child been given information by a parent in any of the following areas? If yes, please check:

   The difference between boys and girls_____

   Birth control_____ Menstruation_____

   How a woman becomes pregnant_____ Wet dreams_____

   How the baby develops and is born_____ Intercourse_____ Masturbation_____

   Other concerns of the parent_____

   _____

PEERS AND INTERESTS

1. Does your child have a best friend?_____

2. Does your child have any difficulty making friends?_____

   Describe_____

   _____

3. Does your child make friends primarily with children his/her own age?_____

   If not, with whom does he (she) make friends?_____

4. Describe any special interests or hobbies:_____

   _____

   Please list any other information_____

   _____

   _____

SAN MARINO PSYCHIATRIC ASSOCIATES

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient's Name:_____ DOB:_____
(Please print clearly)

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the San Marino Psychiatric Associates, A Medical Group, and Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Lupe Quintanilla at 2400 Mission Street, San Marino, CA 91108 or (626) 403-8999.

_____ _____
Signature of Patient, Guardian or *Personal Representative Date

_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

☐ Patient Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date