San Marino Psychiatric Associates
A Medical Group

Office Use Only:

Acct #_____

Provider: _____

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: ( )_____

Email:_____

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.

Copayment amounts are set by your benefit plan. These payments are due and payable at each appointment. The copayment set by your plan for each visit is as follows: $_____

For special modalities of treatment not covered by your benefit plan, a written agreement needs to be signed between you and this office/practitioner.

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

I authorize my insurance carrier to directly pay my practitioner. **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, you will be charged what your healthplan will allow. Please note: in most instances your healthplan allows us to charge our full fee for these visits. Repeated "no-show" appointments could result in a referral back to the insurance company for reassignment to another provider. Your insurance company cannot be billed for fees associated with missed or canceled appointments. **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 are 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

ADULTS ONLY

THE MOOD DISORDER QUESTIONNAIRE

PATIENT _____ SCORE _____ DATE _____

1. *Has there ever been a period of time when you were not your usual self and...*

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❍ yes	❍ no
...you were so irritable that you shouted at people or started fights or arguments?	❍ yes	❍ no
...you felt much more self-confident than usual?	❍ yes	❍ no
...you got much less sleep than usual and found you didn't really miss it?	❍ yes	❍ no
...you were much more talkative or spoke much faster than usual?	❍ yes	❍ no
...thoughts raced through your head or you couldn't slow your mind down?	❍ yes	❍ no
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍ yes	❍ no
...you had much more energy than usual?	❍ yes	❍ no
...you were much more active or did many more things than usual?	❍ yes	❍ no
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍ yes	❍ no
...you were much more interested in sex than usual?	❍ yes	❍ no
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍ yes	❍ no
...spending money got you or your family into trouble?	❍ yes	❍ no

2. ***If you checked YES to more than one of the above, have several of these ever happened during the same period of time?*** ❍ yes ❍ no

3. ***How much of a problem did any of these cause you — like being unable to work; having family, money or legal troubles, getting into arguments or fights?***
Please select one response only.

❍ No Problem ❍ Minor Problem ❍ Moderate Problem ❍ Serious Problem

—Adapted with permission from Robert M. A. Hirschfeld, MD.

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