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.

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

SAN MARINO PSYCHIATRIC ASSOCIATES
A MEDICAL GROUP

Timothy Pylko, M.D.
Sheela Gade, M.D.
Nyssa Adackapara, M.D.
Daniel T. Suzuki, M.D.
Rebecca Najera, D.O.

2400 MISSION STREET
SAN MARINO, CALIFORNIA 91108
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Aura-Marie Pawley, M.D.
Warren R. Christianson, D.O.
Young Ji Jenice Kim, M.D.
Carol McCormick, N.P.

Acknowledge of Acceptance of Patient Financial Responsibility

Patient's Name: _____ DOB: _____

I understand that Timothy Pylko, M.D. is not contracted with any insurance company for office based outpatient services. We do not bill for outpatient services.

The office will provide the patients with a HCFA or itemized statement so they may bill their insurance if there are any out of network benefits. This does not in any way mean that Dr. Pylko accepts the contracted rates suggested by the health plans for these office based services.

The primary relationship in an office based setting is between Dr. Pylko and the patient and not between Dr. Pylko and the insurance company. This also ensures that the insurance company cannot dictate the type of treatment provided by Dr. Pylko to the patient. This treatment is at the core of the doctor-patient relationship and is made in a joint decision between Dr. Pylko and the patient.

The undersigned agrees that the Patient or Patient's legal representative, are responsible for all applicable payments of all charges for office based outpatient services.

_____ _____

Signature of Patient's or Patient's Legal Representative 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.

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?_____

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