

**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.

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.

Patient

Patient's 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	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis/encephalitis	<input type="checkbox"/>	<input type="checkbox"/>
Other hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>			

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	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Swelling/hands, feet	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting, vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion/gas/heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer/pain	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Cough or wheeze	<input type="checkbox"/>	<input type="checkbox"/>	Eating/appetite changes	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Weakness/tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Memory/thinking/ Concentration problems	<input type="checkbox"/>	<input type="checkbox"/>

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? _____

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