Adult Intake

Date of Initial Visit _____

Client Name_____

Home Address

_____

Home Telephone _____ Is it okay to call? Yes ____ No ____

Cell Phone _____ Is it okay to call? Yes ____ No ____

Email:_____ Is it ok to email? Yes_____No_____

Social Security Number_____

Birthdate _____ Age ____

Male ____ Female ____

Marital Status _____

Client Status: Employed _____ Full Time Student _____ Part Time Student _____

Employer_____ Occupation _____

Name of spouse _____

Work Phone_____ Is it okay to call? Yes ____ No ____

Cell Phone _____ Is it okay to call? Yes ____ No ____

Person responsible for deductible, coinsurance, and copayments if other than client:_____

Address :_____

Did you contact your insurance company to verify your benefits and let them know you were coming? _____

Deductible/year $_____ Has it been met?_____ Copayment/coinsurance/visit $_____ or ____%

Did you receive an authorization number from your insurance company? Yes____ No____

Authorization number _____ Number of visits _____

Did you get a referral from your Primary Care Physician if required by your ins. co.? Yes____ No____

Insurance Information		For Secondary Ins. Only	
Policy Holder's ID/SS#	_____	Policy Holder's ID/SS#	_____
Ins Co. Name	_____	Ins. Co. Name	_____
Policy Holder's Name	_____	Policy Holder's Name	_____
Relationship to client	_____	Relationship to client	_____
Policy Holder's Address	_____	Policy Holder's Address	_____
	_____		_____
Policy/Group #	_____	Policy/Group #	_____
Policy Holder's DOB	_____	Policy Holder's DOB	_____
Male ____ Female ____		Male ____Female ____	
Employer	_____	Employer	_____

HIPAA RULES

New HIPPA (Health portability and accountability act) privacy standards were created to protect patients' health information when it is disclosed but also to facilitate the flow of medical information between providers. With other medical providers and for safety or security reasons, there is less protection of confidentiality than there used to be. However, in other areas, there is more privacy protection. Please read the following so that you understand your rights as a patient as well of the new rules about patient confidentiality. Feel free to ask about privacy, confidentiality, or psychiatric records.

1. *Permission from patient is no longer required for transfer of psychiatric and medical information between providers as long as only the necessary information is supplied.* This means that if your primary care doctor, pharmacist, or an emergency room physician calls to find out if you (or your child) are in treatment what the diagnosis is, or what medication you (or your child) are on. We can convey this information if it is medically relevant to your (or your child's) treatment with them. In practice, we will almost always discuss this with you personally before or after the fact, depending on the urgency and depth of the request. If you think this might present a problem for you let us know ahead of time.

2. *Remember if all the psychiatric records are requested, a treatment summary is usually given instead*, except if the treatment consists solely of psychopharmacological treatment or brief medication visits. While brief medication visits fall under HIPAA guidelines, psychotherapy visit are specifically excluded, meaning authorization from the patient is still required for the release of information in those notes and a summary is given in place of the record.

3. The substance abuse records from alcohol and drug programs are exempt from any disclosure with out patient permission. If you

(or your child) are admitted to a treatment program for substance abuse, be sure to sign a release so that we can talk to the providers and obtain a discharge summary and lab data upon discharge. Without this we cannot obtain any information.

4. We may have to disclose some psychiatric information as required to do so by law without your consent. This includes mandated reporting of child/elder abuse and cases of legal order or subpoena.

5. *National security and public health issues.* We may be required to disclose certain information to military authorities or federal health officials if it is required for lawful intelligence, public health safety, or public security.

Individual (patient) Rights.

1. All patients have the right to inspect and copy their own protected health information (medical record) on request for mental health records, which must be reviewed with a psychiatrist first. In cases where exposure to the record might be harmful to the patient, the psychiatrist may deny the request. If you request a copy of your psychiatric record, we will generally review the record with you. It is unlikely that there would be information in the chart that a patient should not or could not read, but much of information in the chart may require explanation.

2. Patients also have the right to amend their medical or psychiatric record. Physicians have the right to deny such a request if it is believed that the information in the medical record is accurate, but in that case the patient request must still be attached to the medical record.

3. Patients have the right to an accounting of all disclosures to other parties. This means that if you ask for a list of whom we have released psychiatric information to we will supply it to you.

4. Patients have the right to have reasonable requests for confidential communications accommodated.

5. You can give written authorization to disclose your psychiatric information to anyone you choose, and you may revoke the authorization in writing at any time.

6. Patients can file a complaint with Dr Amin to the Medical Board of California (800-633-2322). Medical doctors are licensed and regulated by the Medical Board. There will be no prejudice for filing such a complaint.

7. Patients have the right to receive a written notice of privacy practices from providers and health plans.

I have reviewed, understand, and agree to the stated HIPAA Privacy information provided to me.

Signature:---------- DATE:----------
(Patient or guardian)

HEAL PSYCHIATRIC SERVICES, INC.
PRIVATE PRACTICES NOTICE:

EMERGENCIES:

You may telephone your physician in case of an emergency. Your psychiatrist is going to try her/his best to answer your phone as soon as possible. Sometimes your doctor is not always immediately available by phone. If unavailable, your call will be returned as soon as possible. If your doctor is unavailable, or you have an emergency that cannot wait, **you should call 911 or proceed to a psychiatric emergency facility right away.**

I have reviewed, understand, and agree to the stated policies regarding emergencies.

Initials ---------

AFTER-HOURS:

Office phones are answered from 8: AM to 5:00 PM from Monday-Thursday. Office is closed on Fridays, weekends and holidays.

For the office messaging system. Listen to the prompts carefully and leave a message on the appropriate line. Messages can be left for
1. Making appointments, 2. Medication refill request (please leave your full name, phone number, date of birth, pharmacy number, prescription name, dose and how many times per day it's taken). 3. Message for billing issues. 4. Message for your doctor,(please state urgency status urgent, non-urgent, your name, phone number and a brief description of your question).

You understand that every effort will be made by the staff and your doctor to return your call within 1-2 business days. Please leave a message that includes your name and date of birth, explains the nature of the call, and includes information on how to be contacted. *Be aware that messages asking simply to "speak with the doctor", with no other information provided, may not be returned as quickly as a message for a patient stating specific issues they are having, such as medication side effects or change in mood/ behaviors.* You will allow your psychiatrist or designated representative to leave messages on your answering machine/voicemail unless you specifically request otherwise, with the understanding that every effort will be made to maintain confidentiality. You understand that most significant medical or psychiatric questions will need a face-to-face appointment to properly evaluate the situation

You understand that calling the office after regular business hours, weekends, or holidays will provide you information on how to contact the on-call physician. You understand that this service should only be utilized for **urgent matters** that cannot wait until the next business day. Calls placed for non-emergent issues such as medication refills, scheduling or billing issues might not be answered till the next business day.

I have reviewed, understand, and agree to the stated policies regarding after-hour contact.

Initials ---------

PHYSICIAN ABSENCE:

You understand that if you have an emergency while your psychiatrist is on leave, that another psychiatrist may provide covering services. This psychiatrist will have access to your confidential medical information during this time.

I have reviewed, understand, and agree to the stated policies regarding physician absence.

Initials ---------

CONSULTATION: Your doctor consults regularly with other professionals regarding clients; however, patient's name and other identifying information is never mentioned. Your doctor is responsible for maintaining all professional standards set forth in the ethical principles of his professional association as well as the laws of the state of California governing the practice of psychiatry and that is liable for infractions of those standards.

I have reviewed, understand, and agree to the stated policies regarding consultation.

Initials ----------

CANCELLATIONS:

A scheduled appointment means that time is reserved only for you and therefore requires adequate notice if you need to cancel. As your psychiatrist does not "double-book" their schedule. By not keeping your appointment another patient that may have needed to be seen urgently may not have been able to do so.

Cancelled appointments must be made within 1-business day or 24 business hours before your appointment (for example, you must notify your psychiatrist by Friday at 10AM if your appointment is Monday at 10AM).

If such notice is not given 24 hours in advance, or if you fail to show for a scheduled appointment, you will be responsible for set missed appointment fee of 75$ for the missed session **regardless of the reason.**

You understand that repeated late cancellation of appointments and/or failure to keep scheduled appointments may result in termination from Heal Psychiatric Services.

I have reviewed, understand, and agree to the stated policies regarding cancellations.

Initials: ----------

MEDICATION:

1. No refills are done on weekends and public holidays. Please plan ahead.

2. All refill requests must be submitted through the office messaging system. Listen to the prompts carefully and leave a message on the appropriate line.
. Medication refill request (please leave your full name, phone number, date of birth, pharmacy number, prescription name, dose and how many times per day it's taken).

3.You must see your doctor on a regular basis to obtain your medication. You should see your doctor at intervals decided by you and your doctor. In order to make sure that all patients are

carefully monitored for any side effects, you should see your doctor at least once every 6 months if you have been doing well and stable on your medication. No medication refills will be provided if you have not seen your doctor for over 6 months, and your care will be automatically terminated if you have not seen your doctor for over a year.

4. All refills take up to a MINIMUM of 3 days and typically are filled within 5 days (assuming you are requesting the refill in writing and you have an upcoming appointment). Please allow this much time for mistakes and problems.
We suggest keeping a 7-day supply of your medication in a separate bottle to avoid last-minute requests.

5. You will not make any changes in your medication without first discussing it with your doctor. Frequent changes in medication without consulting with your doctor may result in termination of your care.

6. No new mediation is started over a phone conversation. If you want to start/discuss a new medication, Please call and make an appointment with your doctor. No exceptions.

7. In case your medication requires a prior authorization, your doctor will generate a prior authorization request with your insurance company on working weekdays. It usually takes 2-5 days for insurance companies to decide. Please call your pharmacy and ask them to run your medication request again in a couple of days or call your insurance to inquire about the progress of your request.

8. Please call your pharmacy **BEFORE** calling your doctor's office. Most of the time you have refills available and you don't need to contact your doctor's office to get your medication.

9. Stimulant medications for ADD/ADHD are controlled substances and refills cannot be called/faxed into a pharmacy, per state law and regulations. Rather, a paper prescription form must be submitted to the pharmacy for stimulant medications to be filled. These medications will not be filled on days the office is closed including Fridays/weekends/holidays.

10. There is a 10$ charge for **URGENT PRESCRIPTIONS REQUESTS**, to be filled within 24 hours of putting in written request.

I have reviewed, understand, and agree to the stated policies regarding medication.

Initials ---------

FINANCIAL RESPONSIBILITY:

The person who signs this financial responsibility agreement is responsible for payment on your account. If you wish to designate someone other than yourself as the person financially responsible for your account, that person must sign the financial responsibility agreement. Neither Heal Psychiatric Services or any of it's doctors are responsible for contacting your insurance company about reimbursement issues.

In the situation of divorced or separated parents of a child patient, one parent must be designated as the primary financially responsible parent who will make payments on the child's account, with any division of payment decided privately between the parents.

You agree to notify Heal Psychiatric Services of any changes in your account information and understand that a new Financial Responsibility Agreement may then be required.

A credit card on file is required for automatic billing of unmet deductibles, no-show fees, charges for records, letters, forms etc. Overdue amount will be charged to your credit card on account if not paid after the first statement.

I have reviewed, understand, and agree to the stated policies regarding financial responsibility.

Initials ---------

Administrative Fees for Letters/Forms/School related paperwork/ copying medial records.

Your doctor will help you with filling out any paperwork needed for work, school etc. There is a fee for getting these done. If you want to avoid these charges, please make an appointment and your doctor will fill these out during your appointment.

1. Letters for work, school Forms: 25-50$

2. Short Term Disability Forms: 35-50$ (Please be advised, We **DO NOT** do LONG TERM DISABILITY or PERMANAENT DISABILITY EVALUATIONS OR RECOMMENDATIONS. In order to fill your SHORT TERM DISABILITY APPLICATION, It is mandatory that you be enrolled in an Intensive Out-Patient Program (IOP) or in a Partial Hospitalization Program (PHP).

3. Remember that if the psychiatric records are requested, a treatment summary is usually given instead, except if the treatment consists solely of psychopharmacological treatment or brief medication visits. While brief medication visits fall under HIPAA guidelines, psychotherapy visits are specifically excluded, meaning authorization from patient is still required for release of information in those notes and a summary is given in place of the record. There is a charge of 35-50$ for writing such a summary.

4. Photocopying of Medical Records. 25-35$ depending on the size of medical records.

Your records will be faxed to another physician without any cost. But there is a cost for mailing these medical records.

I have reviewed, understand, and agree to the stated policies regarding administrative fees.

Initials ---------

INSURANCE :

Please understand that each of these companies listed on the company's website may have different plans and our doctors are not providers for all of them. Hence even if you have a plan with one of these companies, your visit may still not be covered because the doctor you are seeing is not a provider in your ***plan***. Please call your insurance company and verify that you have coverage. Please find out your deductibles. Often these are very large.
If you are seen by the doctors and your insurance deems the charges not eligible, you will

be responsible for them. This is true even if the preliminary check with insurance company by us indicates that you are covered and you are seen with the expectation that we will bill your insurance. Until the claim is completed by the insurance, we can not positively know if you are covered.
Some services such as phone consultations with other providers, review of records, urgent prescription refills, no-show charges, cancellation fees, form filling, reports etc. are often **NOT** a reimbursable expense. If these services are used or requested by you, you are responsible for their charge. Your insurance company will not pay for most of these.

In the event that payments are not received in a timely manner, delinquent accounts will be assigned to a collection agency.

All phone consultations are self-pay. Most insurance companies do not cover any phone consultations. Phone consultations are billed at the rate of 300$/hr.

I have reviewed, understand, and agree to the stated policies regarding Insurance coverage.

Initials ---------

TERMINATION:

Our doctors accept a patient into treatment in an effort to determine whether he or she can benefit from the services available. If in the opinion of our doctors, he or she is not able to benefit, withdrawal will be recommended. In such a case, you will be given a number of referrals that may be of help. If at any time you want another professional's opinion or wish to consult with another psychiatrist, you will be assisted in finding someone qualified, and if your consent has been given, your psychiatrist will provide the essential information needed. You have the right to terminate treatment at any time. If you choose to do so, your doctor will offer to provide you with names of other qualified professionals whose services you might prefer.

You must see your doctor on a regular basis to obtain your medication. You should see your doctor at intervals decided by you and your doctor, In order to make sure that all patients are carefully monitored for any potential side effects; you should see your doctor at least once every 6 months. No medication refills will be provided if you have not seen your doctor for over 6 months, and your care will be automatically terminated if you have not seen your doctor for over a year.

I have reviewed, understand, and agree to the stated policies regarding termination

Initials: ----------

ARBITRATION/MEDIATATION AGREEMENT:

You agree to address any grievances You may have directly with your psychiatrist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be

sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law. *By signing this contract you are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial.* It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently rendered, will be determined by submission to arbitration as provided by California law and in accordance with the rules of the American Arbitration Association, and not by lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above-identified grievance procedures.

I have reviewed, understand, and agree to the stated policies regarding arbitration/mediation.

Initials ----------

SUBPOENA/COURT APPEARANCE:

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

I have reviewed, understand, and agree to the stated policies regarding subpoenas/court appearance.

Initials ----------

You have read this informed consent completely and have raised any questions you might have about it with your doctor. You have received full and satisfactory response and agree to comply with all items freely and without reservations.

_____

_____ Signature of Patient/Legal Representative Print Name / Date

_____

_____ Signature of Patient/Legal Representative Print Name / Date

_____

Clinician Signature /Print Name / Date

CEDIT CARD AUTHORIZATION FORM

I, the undersigned individual, authorize Heal Psychiatric Services, Inc. to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify your doctor at least 24 business hours in advance for a cancelled appointment. Furthermore, for outstanding payments of services rendered, I authorize Heal Psychiatric Services, Inc. to charge my credit card for the full amount due. I agree to not dispute charges for any of these reasons. I further authorize them to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge.
Missed sessions or late cancellations are charged 75$ for follow-up appointments and 75$ for initial evaluation.

Card Type (please check one): Visa MasterCard Amex Discover

Card #: _ _ _ _- _ _ _ _- _ _ _ _- _ _ _ _

Expiration: _ _/ _ _ Security code*: _ _ _

* This is a 3-digit code located on the back of your card.

Name (as printed on card):
_____
Name of patient if credit card holder is not the patient:_____
Billing Address:
_____

Signature: _____
_____
(Patient or financially responsible party)
Date

HEAL PSYCHIATRIC SERVICES:
1710 S. Amphlett Blvd., Suite 301, San Mateo, CA, 94402
Ph# 650-2734082 Fax# 650-275-7559

Release of Information

I hereby authorize: □ Farzana Amin M.D.
□ _____
To:
□ Release information to:----------
□ Obtain information from: _____
□ Exchange information with: _____

Telephone: _____

The information requested or authorized for release or exchange pertains to:
□ Mental Health
□ Education
□ HIV/AIDS
□ Sexually transmitted diseases
□ Drug or alcohol abuse
This authorization is valid for one year from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patients Name Date of Birth

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date