# *Inland Pacific Psychological Services*

## NEW PATIENT REGISTRATION

**The following questions are designed to help us to better understand your care needs. Please answer as completely as possible. We will be happy to assist you if you have any questions.**

**Date: _____**

**Patient Name _____ Gender: _____**

**Patient Social Security # _____ Date of Birth _____**
**(MM/DD/YYYY)**
**Address _____ Apt. # _____**

**City, State _____Zip Code _____**

**Primary Phone (_____) _____ Secondary Phone (_____) _____**
*Please Circle:* Home or Cell /OK to contact there? Y N *Please Circle:* Home or Cell /OK to contact there? Y N

**Email Address: _____ Other Phone (_____)_____**
(See email disclaimer pg. 5)

**Race _____ Ethnicity_____ Preferred Language _____**

**Emergency contact: _____ _____ (_____) _____**
**Name Relationship Phone Number**

### Please list others living in your household:

| Names | Ages | Names | Ages |
|---|---|---|---|
| **1.** _____ | | **4.** _____ | |
| **2.** _____ | | **5.** _____ | |
| **3.** _____ | | **6.** _____ | |

**Referred by: _____**

**Primary Care Physician _____ (_____) _____**
**Name Phone Number**

### Primary Insurance Information

**Insured Name _____**

**Insured SSN _____**

**Insured Birthdate _____**

**Employer _____**

**Health Plan _____**

**Phone number (_____)_____**

**Subscriber ID# _____**

**Effective Date: _____**

### Secondary Insurance Information

**Insured Name _____**

**Insured SSN _____**

**Insured Birthdate_____**

**Employer _____**

**Health Plan _____**

**Phone number (_____)_____**

**Subscriber ID# _____**

**Effective Date: _____**

## ***Appointment Phone Call/ Text Messages***

**We send out courtesy reminders 2 business days prior to your appointment. Please indicate below how you would like to receive your appointment information.**

**Phone (_____) _____** *Please Circle:* CALL TEXT

**Please indicate the severity of problems in the following areas of your life:**

| | No Problems | Mild | Moderate | Significant | Severe | Not Applicable |
|---|---|---|---|---|---|---|
| **Depression** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Anxiety** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Anger** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Self-esteem** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Marriage/Relationship** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Family** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Friendships** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Work or School** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Money** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Legal Issues** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Eating habits** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Sleep** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Substance Abuse** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Concentration** | **1** | **2** | **3** | **4** | **5** | **N/A** |
| **Behavior** | **1** | **2** | **3** | **4** | **5** | **N/A** |

**What do you view as your strengths at this point in your life?**

**Please use the space below to provide any other information you feel might be important:**

**Patient Name: _____**

**Please describe your reason for seeking treatment at this time:**

**Please describe any significant current stressors or issues in your background or history which may be related to the current problem:**

**Have you received mental health treatment before? _____ Yes _____ No If yes, please describe:**

**Do you have any medical problems? _____Yes _____ No If yes, please describe:**

**Are you currently taking any medications? _____Yes _____ No If yes, please list names and dosages:**

**Do you use tobacco? _____ Yes _____ No**

**If yes, how much? _____ How often _____ Last taken _____**

**Do you consume alcohol? _____Yes _____ No**

**If yes, how much? _____ How often _____ Last taken _____**

**Please list any drugs you have experimented with:**

| **Drug** | **Amount** | **Frequency** | **Last taken** |
|---|---|---|---|

**Patient Name: _____**

# *Inland Pacific Psychological Services*-CONSENT FORM Page 1 of 3

**Treatment Philosophy-Explanation of Brief Therapy**

Brief therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a timely manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask.

**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 vs. County of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff vs. Regents of University of California, 1967).
5. Elder abuse and /or neglect are suspected (Welfare & Institution and/or Penal Codes).
6. Child abuse and/or neglect are suspected (Melendez Chapter 264, Statues of 2014)

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.

**Initial here: _____**

**HIPAA Compliance**

Our practice complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review the Notice of Privacy Practices posted in the waiting room. You may request a copy of this notice and of your treatment records if you wish.

_____I have had an opportunity to review the Notice of Privacy Practices.

In addition: I authorize release of information pertaining to claims, certification, case management, quality improvement, benefit administration and other related purposes to my health plan. I authorize release of information **to Inland Pacific Psychological Services'** treatment professionals for purposes of coordination of treatment and peer review.

_____I authorize release of information to my Primary Care Physician.

_____I do not authorize release of information to my Primary Care Physician.

**Initial here: _____**

# *Inland Pacific Psychological Services*-CONSENT FORM Page 2of 3

**E-Mail Disclaimer:** Please note that if the patient/legal guardian provides our practice with an e-mail address, the patient/legal guardian is providing **Inland Pacific Psychological Services *(IPPS)*** with automatic authorization to communicate medical (and account) information to the patient/legal guardian and/or any of their elected representatives, via that e-mail address. Additionally, this authorization allows our practice to e-mail medical information to any healthcare provider directly involved in the care of the patient (and who elects to communicate via e-mail). If the patient/legal guardian elects not to have any information communicated via e-mail, the patient/legal guardian is hereby instructed to not provide our office with an e-mail address and to provide our office with written notification prohibiting the sharing of the patient's information electronically with any entity.
**Initial here: _____**

**Emergency Access**
Practitioners are available after hours to handle emergencies. Your provider will discuss after hours procedures with you. For life threatening emergencies, you should dial 911 or go to the nearest emergency room.
**Initial here: _____**

**Financial Terms- Insurance Coverage and Co-payments**
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 & Late Cancellations *are not covered* by your insurance and the charges associated with them are your responsibility.

Co-payment amounts are set by your benefits plan and are expected to be paid at the time of service.
We will make every effort to inform you of costs when you are beyond or outside your benefits. For special modalities of treatment not covered by your benefits plan, a written agreement needs to be signed between you and **Inland Pacific Psychological Services**. This agreement will outline your understanding that the services are not covered and the fees and the treatment plan you may expect.

I will notify practitioner before services are rendered if there are any changes in insurance carrier and/or coverage. If I become ineligible for insurance coverage, I will notify the practitioner and understand I will become responsible for 100% of the bill.
**Initial here: _____**

**Cancellation and Missed Appointment Policy**
Scheduled appointment times are *reserved especially for you*. We make every effort possible, as a courtesy, to give you an appointment reminder via an automated appointment reminder system but if an appointment is ***missed*** or ***not canceled by noon the business day prior to the appointment***, *you* will be charged according to our scheduled/posted fee and instructions of your benefit plan. Please speak with the receptionist for current fees. Repeated "no show" appointments could result in referring you back to the insurance company for reassignment to another practitioner. Your insurance company *will not be billed* for fees associated with missed or canceled appointments. Rescheduling or cancelling on the part of the provider does not transfer to a monetary amount, therefore provider cancellation is not included in this clause.
**Initial here: _____**

# *Inland Pacific Psychological Services* -CONSENT FORM Page 3 of 3

**Appeals and Grievances**

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified. I understand that I would request an Appeal directly through my insurance company and that I risk nothing in exercising this right.

I also understand that I may submit a Grievance to my Practitioner at any time to register a complaint about my care or I may send the complaint directly to my insurance company.

I understand that the California Department of Managed Health Care (DMHC) is responsible for regulating health care services. The California DMHC has a toll-free telephone number **(800-400-0815)** to receive complaints regarding health care plans. If I have a grievance involving an emergency appeal or with an appeal that has not has not been satisfactorily resolved by the plan, I can call the DMHC's toll free telephone number.

**Initial here: _____**

_____ _____

**Patient Name (Please Print)** **Date**

**Consent for Coordination with Insurance company**

I hereby authorize the release of information to my insurance company as necessary to obtain authorization and payment of medical benefits to the physician/therapist for services rendered. I also authorize use of a photocopy of my signature to file insurance claims. I further authorize my insurance company to issue payment to **Inland Pacific Psychological Services** for services rendered.

**Initial here: _____**

_____ _____

**Patient Name (Please Print)** **Date**

**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 Signature** **Date**

**General Consent for Child or Dependent Treatment**

I/We, _____

**Print** Name(s) of Legal Guardian(s)

being the legal guardian(s) or legal representative(s) 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 and obligations* described in this statement apply to the patient I/we represent. I/we agree to assume full financial responsibility for *all* charges not covered by insurance.

_____ _____

Signature of Legal Guardian/Legal Representative Relationship to Patient

_____ _____

Signature of Legal Guardian/Legal Representative Relationship to Patient