ORANGE PSYCHIATRIC MEDICAL GROUP
4510 Brockton Ave Ste 375
Riverside, CA 92501
Ph: 951-276-1100 Fax: 951-276-1105

PATIENT INFORMATION SHEET
PLEASE PRINT

PATIENT'S NAME * _____
LAST FIRST MI

HOME PHONE# * **( ) _____ WORK PHONE # ( ) _____**

CELL PHONE # ( ) _____ MARITAL STATUS: M S D / W

STREET ADDRESS * _____

CITY/ZIP * _____

SEX * **M F D.O.B.** * _____

RACE * _____ **HISPANIC ORIGIN? Y OR N**

PHARMACY USED: * _____

WHOM SHOULD WE THANK FOR YOUR REFERRAL? _____

INSURANCE INFORMATION

SUBSCRIBER'S NAME * _____

PRIMARY INSURANCE * _____

ID# * _____ **SS#** * _____ **D.O.B.** * _____

RELATIONSHIP TO PATIENT * _____

SECONDARY INSURANCE * _____

ID# * _____ **D.O.B.** * _____

--EMERGENCY CONTACT--
INFORMATION ON NEAREST RELATIVE OR FRIEND

NAME * _____ **PHONE #** * _____

_____ _____
DATE **SIGNATURE OF PATIENT / LEGAL GUARDIAN**

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FINANCIAL POLICY

Please understand that payment of your bill is considered a part of your treatment. OPMG will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Co-payment amounts may vary during the course of treatment, as outlined by your plan. Co-payments are due at each appointment.

Returned Checks
The charge for a returned check is $15. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Records
There is a fee of $30 for copies of medical records.

If at any time during your treatment you become ineligible for coverage by your insurance, you will be responsible for 100% of your bill. You are responsible for obtaining any prior authorization for treatment from your insurance carrier. For special modalities of treatment not covered by your benefit plan, a written agreement will be signed between you and your clinician. This agreement should cover the fees and treatment plan and should never contain fees more than the fee-for-service, discount rates that your benefit plan provides.

Minor Patients:
The adults accompanying a minor and the parents or guardians are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment plan or payment by cash or check at time of service has been verified.

Missed Appointments:
Unless cancelled at least 24 hours in advance, there will be a $40.00 charge for missed appointments. Emergency situations will be considered. Please help us serve you better by keeping scheduled appointments.

Miscellaneous Fees:
Providers completing additional documents (Letter completion, disability, etc), will have a fee ranging from $10-60, depending on the document.

Please sign below indicating your understanding of OPMG's financial policy:

Patient or Guardian's Signature _____ **Date** _____

ASSIGNMENT OF BENEFITS

Authorization to Pay Benefits to Provider

I hereby authorize payment directly to the Provider of service for mental health benefits, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services.

_____
Signature of Patient, Legal Guardian/ Legal Representative

_____
Name (Printed)

_____
Relationship to the Patient

_____ _____
Patient Name (if different from the one above) Date

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Mental Health Disclosure Form

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 time efficient 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 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 Code*).

  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(s) or agency. If group therapy is utilized as part of the treatment, details of the group discussion is 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. 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:**_____

Emergency Access

- Practitioners are available after hours to handle emergencies. By calling the main office number during after hours, you will be instructed how to contact the on-call practitioner. **Initial here:**_____

Consent for Treatment

- I authorize and request my practitioner carry out psychological 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 Signature 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 Name Signature of Legal Guardian/Legal Representative

_____
Date

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Consumer Notice of Rights and Responsibilities

Dignity and Respect

- You have the right to be treated with consideration, dignity and respect – and the responsibility – to respect the rights, property and environment of all physicians and other health care professionals, employees and other patients.
- You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational or religious background.

Knowledge and Information

- You have the right to receive information about the organization's services and practitioners, clinical guidelines, and member's right and responsibilities.
- You have the right – and the responsibility – to know about and understand your health care and your coverage, including:
  - Participating with your physician and other healthcare professionals in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
  - The names and titles of all health care professionals involved in your treatment.
  - Your clinical condition and health status.
  - Any services and procedures involved in your recommended course of treatment.
  - Any continuing health care requirements following your discharge from a provider's office, hospital, or treatment program.
  - How your health plan operates – as stated in your Policy and/or Certificate.
  - The medications prescribed for your – what they are for, how to take them properly and possible side effects.

Patient or Guardian's Signature _____ Date _____

PATIENT ACKNOWLEDGEMENT OFNOTICE OF PRIVACY PRACTICES

I have received Notice of Privacy Practices, and understand that Orange Psychiatric Medical Group, Inc. has certain legal duties to safeguard my Protected Health Information (PHI). I also understand that I have certain rights in regard to my (PHI).

Patient or Guardian's Signature _____ Date _____

HEALTH CARE COORDINATION FORM

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

PATIENT NAME:_____**DOB:**_____

I hereby authorize the release of the medical information listed below which pertains to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and /or substance abuse diagnosis and treatment to my primary care physician:

_____
Physician Name

_____
Address

_____
Phone Number/Fax Number

I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care, which I may receive from specialists. I further understand that I have a right to receive a copy of this authorization upon my request. This authorization becomes effective on the date signed and may be revoked by me at anytime, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to this recipient only with signed consent from me.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

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SYMPTOMS IDENTIFICATION LIST

PATIENT'S NAME _____

Please state your present problem(s) and the length of time you have experienced it/them:

_____

_____

_____

Please take a few minutes to complete this survey. Circle the number that applies to you. The numbers range from 0-5 depending upon the severity of the symptom.

	0	1	2	3	4	5
	(no problem)					(severe problem)
Nervousness	0	1	2	3	4	5
Nightmares	0	1	2	3	4	5
Poor memory	0	1	2	3	4	5
Poor concentration	0	1	2	3	4	5
Worry all the time	0	1	2	3	4	5
Panic attacks	0	1	2	3	4	5
Feelings of dread	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Sadness	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5
Loss of interest in activities	0	1	2	3	4	5
Weight loss	0	1	2	3	4	5
Extreme tiredness	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Suicidal thoughts & plans	0	1	2	3	4	5
Suspiciousness	0	1	2	3	4	5
Hearing voices	0	1	2	3	4	5
Feelings of hopeless/helplessness	0	1	2	3	4	5
Loss of interest in sex	0	1	2	3	4	5
Impulse control problems	0	1	2	3	4	5
Sleep Problems	0	1	2	3	4	5