Folsom Psychiatry Associates
Hisham Soliman MD, MPH

PATIENT INFORMATION

Your health is of utmost importance to us. To assist in your evaluation, please fill out this form as accurately as possible. All information will be treated confidentially.

Last Name: ________________________________ First Name: _________________________ MI: ________________

Address: _____________________________________ City: ___________________ State: ________ Zip: ___________

Home Phone: _____-_____- ______ Cellular: _____-_____- ______ Work Phone: _____-_____- ______

May we contact you at home? _____Yes _____No May we contact you at work? _____Yes_____No

Email address: ____

Date of Birth: _____-______-_________ SSN: _______-_______-________ Sex: Male ________ Female_______

Marital Status: _____Married _____Single _____Widowed _____Divorced _____Separated

Preferred Language: _____________

RACE:

_____ Caucasian or white
_____ Black or African American
_____ Asian
_____ Native Hawaiian or other Pacific Islander
_____ American Indian or Alaska Native
_____ Other
_____ Not reported or refused

_____ Hispanic or Latino
_____ Not Hispanic or Latino

Is this visit due to an accident of any kind? _____Yes _____No

Spouse Name: _____________________________________ Spouse SSN: __________ - __________ -___________

Parent/Guardian Name: ____________________________ Parent/Guardian Number:________________________

PERSON FINANCIALLY RESPONSIBLE: Same as patient check here: ________

Name: ____ Relationship to Patient: _____________________________

Address: _______________________________ City: ___________________ State: ___________ Zip: __________

SSN: _______ - ________ - _________ DOB: _____________Employer: ___________________________________

Home Phone: _____-_____- ______ Work Phone: _____-_____- ______ Cell Phone: _____-_____- ______

Are you covered by an employer's health insurance plan or that of a family member? ___________

INSURANCE INFORMATION: Does your insurance provide benefits for mental health services? ________________

Does your insurance require pre-authorization for mental health services? ________ Do you have authorization? _________

Does your insurance have a maximum number of visits per year? __________ If so, how many? ________________

PRIMARY INSURANCE:

Primary Insurance Company: ________________________________ Phone Number: _____-_____- ______

Policy Holder's Name: _____________________________DOB: __________ Relationship to Patient: ___________

Policy Number: _____________________________________ Group Number: ________________________________

Policy Holder's Employer: ____ Co-Pay Amount: _________________

SECONDARY INSURANCE:

Secondary Insurance Company: _______________________________ Phone Number: _____-_____- ______

Policy Holder's Name: ________________________________ DOB: _______ Relationship to Patient: ____________

Policy Number: _____________________________________ Group Number: ______________________________ Policy

Holder's Employer: ____Co-Pay Amount: __________________

Folsom Psychiatry Associates, Inc

INSURANCE RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS: I authorize Folsom Psychiatry Associates to release to my Medicare carrier or the Insurance carrier listed above, any medical information needed for authorization or payment of this or a related claim. I also authorize payments directly to this office for the mental health benefits. I understand that I am responsible for all pre-authorizations required by my insurance. Furthermore, I understand that I am financially responsible for all charges whether or not paid by my insurance company.

FINANCIAL AGREEMENT

Pre-Authorization for Mental Health Services: Most insurance companies require pre-authorization for mental health services. We strongly encourage you to contact your insurance to inquire about any pre-authorization requirements. You may also want to obtain information regarding your mental health benefits. Most often, health insurance benefits for mental health are different from the benefits for general healthcare. Please contact our billing office should you have any questions regarding the information from your insurance. **Payment of Services:** Patients are required to pay all co-pays, co-insurance and balances on account at the time of service. In the event that payment cannot be made, a statement will be mailed and payable within 10 days of receipt. If payment cannot be made when due, you must contact our Patient Accounts Department to set up a payment plan. After 90 days, if no payment has been received, necessary collection proceedings will begin. It is important that you notify us of any changes of address promptly since undeliverable statements are turned over to collections immediately. **Insurance:** If you have insurance, Valley Medical Billing will complete and mail an insurance claim on your behalf. However, you are responsible for all pre-authorization requirements, insurance claim follow up, and all charges not covered by your insurance. Please contact your insurance to inquire about the portion of charges they will pay, prior to receiving your first explanation of benefits. It is often the case that insurance benefits for mental health are different from primary care. If you do not receive an explanation of benefits from your insurance company within 30 days of your date of service, please follow up with your insurance on the delayed claim. After you have spoken with your insurance company; please call the billing department at 800-807-9843, to inform us of the progress on the claim. Valley Medical Billing reserves the right to charge the patient the full amount of the visit if there is no response from the insurance company within 45 days. If you have any questions regarding your account or the filing of your insurance claims, please call us at 800-807-9843. We will be happy to assist you.

Appointment No-Show Fee: I have been advised that this office requires a 48-hour prior notice on all appointment cancellations. I have been advised that there will be a $150.00 no show fee for initial evaluation appointments. For current patients, 50.00 for first no show and 75.00 for second no show and 100.00 for third no show and any thereafter that are canceled with less than 48 hours notice. This fee is not covered by any insurance plan.

I understand and agree to abide by the above Insurance Release of Information/Assignment of Benefits and the Financial Agreement.

Signature of Patient/Guarantor: X ___________________________ Date: ________

EMERGENCY CONTACT:

Name: ____ Relationship: _________________________________

Home Address: __________________________________ City: ________________ State: _______ Zip: ___________

Home Phone: _____-_____- ______ Work Phone: _____-_____- ______ Cell Phone: _____-_____- ______

Folsom Psychiatry Associates, Inc

AUTHORIZATION FOR MEDICAL TREATMENT, STATEMENT OF RESPONSIBILITY, ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES, PATIENT RIGHTS & RESPONSIBILITIES, and MAGELLAN MEMBER RIGHTS & RESPONSIBILITIES

Patient's Name: ____ Patient's Date of Birth: ___________

___**Authorization for Medical Treatment**: I authorize the physician(s), psychologist(s), therapists(s), their assistants and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Folsom Psychiatry Associates. ("Facility). This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests, and the use of prescription medication. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or therapist(s) whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating physician(s) and the Facility will follow the instructions of my physician(s) in the provision of said care.

___**Statement of Responsibility**: I understand that I am financially responsible to the Facility(s) as the patient, parent, guardian, and conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, or out-of-pocket expenses.

___**Notice of Privacy Practices:** I have been given the opportunity to review the Facility's Notice of Privacy Practices for Protected Health Information. I understand that the Facility has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

___**Patient Rights & Responsibilities:** I have been given the opportunity to review the Facility's Patient Rights & Responsibilities. I understand that the Facility has the right to change the Patient Rights & Responsibilities at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient/Guardian Signature: X ____________________________________

Printed Name: ____

Date: _________________________

IMPORTANT PATIENT INFORMATION

The providers and staff of Folsom Psychiatry Associates, Inc feel that we can better serve your health care needs if you are familiar with the following policies and procedures:

Office Hours and Appointments: The office is open Monday through Thursday from 10 a.m. to 7:00 p.m. and our office is closed 12:00 pm to 1:00 pm for lunch. Appointments are available on Saturdays from 9:00 AM till 3:00 pm. The providers are available on an emergency basis at all times. Follow up appointments should be made when leaving the office. However, appointments may also be scheduled by calling 916-351-9400. When you arrive for an appointment, due to the unscheduled nature emergencies impose upon the providers, occasional delays may occur. We hope that you will understand that these delays are unavoidable.

Cancellations: If you are unable to keep your appointment, please cancel at least 48-hours prior to your appointment time and we will be happy to reschedule your visit. Some other patient who can be seen during the open time will be grateful for your thoughtfulness. Folsom Psychiatry Associates also reserves the right to charge for patient no-shows for medical appointments. A $50 no show fee is charged for all first no shows, $75 no show fee for second no show and $100 for third and any no show thereafter.

Prescription Refill Requests: It is important that we closely monitor your medication and therefore, we require that you schedule an appointment prior to requesting a prescription refill. For refills of medication that require a written prescription, please call our office at 916-351-9400 and select the option for medication refill. For all other medications, please call your pharmacy to request a refill and we will respond to your pharmacy as soon as possible. Please note that most medications require insurance authorization and this process can take 3-4 days. If you miss your appointment, no refills will be given.

Telephone Calls: You may call our office to ask a question, report a medication side effect, or the worsening of a condition. We will make every effort to return your call as soon as possible. Most often, calls will be returned promptly. Any voicemails left after hours will be returned the next business day. If you encounter a true medical emergency, call 911.

Patient/Guardian Signature: X ______________________________________

Printed Name: ____

Date: _________________________

CONFIDENTIAL PATIENT INFORMATION

Your health is of utmost importance to us. To assist in your evaluation, please fill out this form as accurately as possible. All information will be treated confidentially.

Date: ___________________

Name: ____ **DOB:** _______________________

Primary Care Provider: _______________________________________ **City/State:** ___________________

Please explain the reason for your visit and how we can help:

____

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____

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<u>IF APPLICABLE, EDUCATION AND SCHOOL HISTORY:</u>

Patient's School: _______________________________________ **Patient's Grade in School**: ____________

<u>REFERRAL INFORMATION</u>: Whom may we thank for referring you to our office?

____Referring Doctor or other medical provider: __________________________________

____Therapist or counseling center: ____

____Hospital, nursing home, or other facility: ________________________________

____Friend or Family Member: ____

____Online or website: ____

May we provide your Primary Care Provider <u>and</u> Referring Provider with your individual health information to assist in the coordination of your health care? ________**Yes** ________**No**

Signature: X ____ **Date:** ___________________

FOLSOM PSYCHIATRY ASSOCIATES

Patient Rights and Responsibilities Statement

Patients have the right to:

Be treated with dignity and respect.

Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.

Have their treatment and other member information kept confidential. Only where permitted by law may records be realesed without member's permission.

Easily access care in a timely fashion.

Know about their treatment choices. This is regardless of cost or coverage by their benefit plan. Share in developing their plan of care.

Receive information in a language they can understand.

Receive a clear explanation of their condition and treatment options.

Receive information about clinical guidelines used in providing and managing their care. Ask their provider about their work history and training.

Give input on the patient's Rights and Responsibilities policy.

Know about advocacy and community groups and prevention services.

If asked, your insurance company may act on the member's behalf as an advocate.

Freely file a complaint or appeal and to learn to do so.

Know of their rights and responsibilities in the treatment process. Request certain preferences in a provider from your insurance company.

Receive a copy of HIPAA Disclosures. I have received, read, and understand this disclosure.

Receive information about the benefits, risks, and the side effects of all prescribed medications. Patients can ask to have such information reviewed at any time.

If you have any questions about your Rights and Responsibilities, you may contact Dr. Hisham Soliman, MD, MPH at 916-351-9400 or email him at hisham.solimanmd@folsompsychiatryassociates.com.

PSYCHIATRIC EVALUATION QUESTIONAIRE

Name: _______________________________________ SSN:__________ - __________ -___________ Age:_______

Reason for visiting the Psychiatry Office today:

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How did you get to the clinic today? ____

Have you ever been a patient in a Psychiatric Hospital/Mental Health Clinic? __________ If yes, please give the names of the hospitals and the dates:

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____

Have you ever been treated by a Psychiatrist/Psychologist? __________ If yes, please give their names and dates of when you were seen:

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List any medications you are currently taking (dosages and how often you take them):

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____

Do you have any allergies to medications?

____

____

If you have experienced any of the symptoms below:

Depression	________YES	________NO
Anxiety	________YES	________NO
Panic Attacks	________YES	________NO
Mood Swings	________YES	________NO
Anger Problems	________YES	________NO
Violent Outbursts	________YES	________NO
Paranoia	________YES	________NO

Have you ever tried to harm yourself?

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Is there a history of mental illness in your family? ___________ If yes, please list who and what their diagnoses is: ____

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____

Where were you born? ____

How many siblings do you have? ____

Have you ever been married? If so, how many times? ______________________________________

If you have children, please list how many: ____

How many years of education do you have? ____

Do you have any college or specialized training? ___________ If yes, what type?

____

What was your most recent job? ____

How long did you work there? _____________________ Why did you leave this job?___________________

Do you drink alcohol? ___________ Do you use street drugs?___________ If yes, what is the type and frequency of use?____

Please list and describe any other health problems:

____

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Where do you live currently? ____

Who else lives with you? ____

Where do you get your financial support? ______________________________________

Please describe how you spend a typical day. For example:

- What time do you get up?
- What time do you go to bed?
- What do you cook for yourself or others throughout the day?
- Do you visit friends?
- Do you work?
- Do you do household chores?
- Run errands, shop, bathe yourself, dress yourself?
- Is there any hobbies you enjoy?

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After filling this form out please sign in the fields marked signature. If you filled this form out on your computer please print and sign and bring with you to your first appointment.

Patient Signature:____ Date:__________________