Ocean View Neuropsychiatry

PATIENT INFORMATION

Today's Date:

Patient Name:

Patient Address:

Phone: Home: Cell:

Work: E-mail address:

How may we contact you: Home ☐ Cell ☐ Work ☐

Other:

Birth date: Age:

Gender: ☐ Male ☐ Female

Ethnicity: Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Other:

Student? No ☐ Yes ☐ School name:

Education:

Relationship status: Occupation:

Financially Responsible Party (if different from patient):

Relationship to patient: DOB: Phone:

Address:

PRIMARY INSURANCE : Insurance ID #:

Subscriber Name: Relationship to subscriber:

Subscriber Social Security #: DOB:

GROUP #: COPAYMENT $:

SECONDARY INS (IF APPLICABLE) Insurance ID #:

Subscriber Name: Relationship to subscriber:

Subscriber Social Security #: DOB:

GROUP #: COPAYMENT $:

How did you first find out about our services?

Emergency Care Information

Personal Physician: Name: Phone:

Address:

May I contact your personal physician to discuss medical or medication issues and/or coordinate your care?

No ☐ Yes ☐

Family and/or friends to be contacted in an emergency:

Name:

Relationship:

Phone:

Reason for Referral

Please provide a brief description of the major concerns that led you to seek treatment/therapy at this time:

Previous Therapist:

Name of clinician:

Phone Number/Address:

Treatment dates:

Previous Psychiatrist:

Name of clinician:

Phone Number/Address:

Treatment dates:

Describe the problems for which you sought therapy in the past:

Have you been hospitalized for psychiatric or substance abuse problems? No ☐ Yes ☐

If yes, please list:

Facility:

Dates:

Reason:

Do you have any history of suicide attempts or history of assault? No ☐ If yes, please describe:

Family Psychiatric/Medical History:

Mother: Yes ☐ No ☐ , if Yes please list diagnosis:

Father: Yes ☐ No ☐ , if Yes please list diagnosis:

Siblings: Yes ☐ No ☐ , if Yes please list sibling and diagnosis:

Others: Yes ☐ No ☐ , if Yes please list relationship and diagnosis:

Additional comment:

Medications

Please list all current drugs/medications, including over-the-counter:

Name of medication:	Dose	Dates

Any allergies to medications: Yes ☐ No ☐ If yes please list medication and reaction:

If you have a preferred pharmacy, please list the information here:

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone:

Please list all Previous drugs/medications, including over-the-counter:

Name of medication:	Dose	Dates

Physical Health Status

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years

For Women Only: Are you currently pregnant or do you think you might be pregnant? Yes ☐ No ☐.

Are you planning to get pregnant in the near future? Yes ☐ No ☐.

Are you breastfeeding? Yes ☐ No ☐.

For All Patients: Do you currently drive? Yes ☐ No ☐.

Personal Medical History/ROS: **NONE (skip to next page)** ☐

General: Fever/chills	☐	headache, dizziness	☐
Head/Neck: Thyroid Disease	☐	Diabetes	☐
Allergic illnesses (eczema/hay fever)	☐	Bulimia/ Eating Disorders	☐
Renal: Urinary Retention	☐	Liver Disease	☐
Abdominal: Stomach/Intestinal	☐	Neuro: Numbness/tingling	☐
Electrolyte Abnormalities	☐	Anemia/Lymphatic problems	☐
Muscloskeletal: weakness/joint	☐	Resp: Cough/Asthma	☐
Sleep Apnea/Sleep	☐	Vision/Glaucoma	☐
Pelvic pain/STDs	☐	Nose: Septal problems	☐
Heart Disease	☐	High/Low Blood Pressure	☐
Skin: rash/soresnnnnn	☐	Endocrine problems	☐
Psych: Mood changes	☐	Hallucinations	☐
Mouth: sores/dental	☐	Vision problems	☐
Head injuries	☐	Hearing/Ear problems	☐
Seizures, convulsions	☐		

Any signiciant Medical Hospitalizations: Yes ☐ No ☐

Any signiciant Surgical Hospitalizations: Yes ☐ No ☐

If you checked any of the above boxes, please explain

Social/Occupational/School/Family Functioning

How many friends:

How often do you make contact with friends? Regularly ☐ Occasionally ☐ Infrequently ☐ Never ☐

What is your living situation? Live alone ☐

Live with others, with whom?

How do you feel about School/work: Satisfied ☐ Dissatisfied ☐

If Dissatisfied, please explain

Please describe any hobbies or recreational activities:

Please specify behavior and/or academic problems in the comments section below.

Grade/Type of Class

Age

School

Behavior

Tobacco, Drug and Alcohol History:

Do you smoke: Yes ☐ No ☐ , If yes please describe:

Do you use alcohol: Yes ☐ No ☐ , If yes please describe:

Do you use any illicit drugs: Yes ☐ No ☐ , If yes please describe:

Additional Comments:

Ocean View Neuropsychiatry

CREDIT CARD AUTHORIZATION FORM

I, the undersigned individual, authorize Ocean View Neuropsychiatry to charge my credit card in the event that I fail to show for a scheduled appointment or do not notify Ocean View Neuropsychiatry at least ***48 business hours (2 business days)*** in advance if I cannot make an appointment in the amount of 300.00 for initial appointments and 150.00 for follow up appointments and for any Insurance copays/deductibles.

Furthermore, for outstanding payments on services rendered, I authorize Ocean View Neuropsychiatry to charge my credit card for the full amount due. I agree to not dispute charges for any of the above reasons. I further authorize Ocean View Neuropsychiatry to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in my clinical file and may be updated by me upon request at any time.

Please note your credit card will not be charged unless one of the following conditions occur:

1. For services rendered, products purchased, or for any missed or cancelled sessions with less than 48 business hours advance notice.
2. Participation in treatment, or services performed, without payment rendered.
3. For any outstanding balance or bills and interest accrued.
4. For the amount of each check that does not clear the bank, for whatever reason, plus a $35 returned check charge per incident.

Card Type (please check one): Visa ☐ MasterCard ☐ Discover ☐ American Express ☐

Card #:

Expiration Date:

Name (as printed on card):

Security Code (3-digit code on the back of card or 4 digits on front of AMX):

Billing Zip Code:

Billing Address (if different then primary):

Name:

Signature (Legal Guardian if indicated): _____

Date:

INSURANCE REIMBURSEMENT

We may be considered "out of network" for some PPO plans. If you have a health benefits policy that provides mental health coverage, you may be entitled to insurance reimbursement for any provided professional services. You can discuss this with your insurance company by contacting them directly.

INSURANCE CLAIMS: If we accept your insurance and upon verification of insurance coverage and policy limits, we will file claims with the patient's primary insurance upon the patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at the time of service. If at any time during your treatment you become ineligible for coverage by your insurance, you will be responsible for 100% of your bill.

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 $40 for copies of medical records. 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.

PATIENT FINANCIAL RESPONSIBILITY: If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, full payment is expected. Copayments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, checks and credit cards. First visit is charged $395.00 and subsequent visits are $195.00 for 15-20 min sessions.

Regardless of insurance reimbursement (for out of network), full payment for all services is required at the time of each appointment. We can provide you with a super bill that you can submit to your insurance company. Please also note that if reimbursement is pursued by you, most insurance agreements require you to authorize us to provide clinical information directly to them. This can include a clinical diagnosis, historical information, treatment plans or summaries.

MINORS/DEPENDENTS: Children under the age of 18 will require the signature of a responsible party on the registration form. 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.

We do not accept Medicare/Medi-cal patients.

Name:

Signature (Legal Guardian if indicated): _____

Date:

Ocean View Neuropsychiatry

PATIENT CONSENT FOR EXCHANGE OF PROTECTED HEALTH INFORMATION

Patient Name:

DOB:

Guardian's Name: (if applicable)

I authorize Ocean View Neuropsychiatry to exchange Information with:

Exchange of records authorized herein is required for the evaluation and management of the above named person; such exchange will be limited to the following types of information:

This consent may be revoked at any time except to the extent that information has already been released. If not revoked it shall terminate in one year.

Date:

Signature (Legal Guardian if indicated): _____

Ocean View Neuropsychiatry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:

DOB:

Guardian's Name (if applicable):

I, , acknowledge that I have received a copy (available on our website under forms) of Ocean View Neuropsychiatry's HIPAA Notice of Privacy Practices and have read it carefully.

Do you consent to receive automated reminder calls at this phone number? Yes ☐ No ☐

Signature (Legal Guardian if indicated): _____

Date: