Ocean View Neuropsychiatry

PATIENT INFORMATION:

Today's Date				
Patient Name:				
Patient Address:				
DOB			Age	
Phone:	Home:		Cell:	
Email:				
Ethnicity:	Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Other:			
Gender:	☐ Male ☐ Female			
Occupation		Grade in school (if applicable		
Relationship status		Preferred mode of communication		
Parent/Guardian (for minors)		Parent/Guardian occupation		
Parent/Guardian (for minors)		Parent/Guardian occupation		

Financially Responsible Party (if different from patient)

Name		DOB	
Address		Social Security #	
Phone		Relation to patient	

INSURANCE INFORMATION

Primary Insurance Name		Copayment (if any)	
Subscriber Name		Subcriber relation to patient	
Subscriber DOB		Subscriber Phone #	
Insurance ID #		Social Security #	
Secondary Insurance If any		Secondary ID #	

How did you hear about us:

Ocean View Neuropsychiatry

Emergency Contact Information:

Personal Physician		Phone	
Address			
May I contact your physician to discuss care or medication issues		Yes ☐ No ☐	
Family and/or friends to be contacted in an emergency			
Phone		Relation to patient	
Previous Therapist		Treatment date	
Address		Phone	
Previous Psychiatrist		Treatment date	
Address		Phone	
Previous psychiatric hospitalization	Yes ☐ No ☐	If yes, name of facility	
Date		Reason	
Previous history of suicidal attempt	Yes ☐ No ☐	If Yes, please describe	
Previous history of assault	Yes ☐ No ☐	If Yes, please describe	

Family Psychiatric History

Mother	Yes ☐ No ☐	If Yes, please describe	
Father	Yes ☐ No ☐	If Yes, please describe	
Siblings	Yes ☐ No ☐	If Yes, please describe	
Other	Yes ☐ No ☐	If Yes, please describe	

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

Pharmacy Name	
Phone	
Address	

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Reason for Referral:

MEDICATIONS (Please list all current medications including over the counter meds)

Medication Name		Dose		Date	
Medication Name		Dose		Date	
Medication Name		Dose		Date	
Medication Name		Dose		Date	
Medication Name		Dose		Date	

Allergies

Any allergies to medications	Yes ☐ No ☐	If Yes, please describe	

Please list all Previous medications

Medication Name		Dose		Date	
Medication Name		Dose		Date	
Medication Name		Dose		Date	
Medication Name		Dose		Date	
Medication Name		Dose		Date	

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

Do you currently drive	Yes ☐ No ☐

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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 ☐

Review of Systems

General: Fever	☐	Thyroid	☐	Headache	☐	Dizziness	☐
Eczema	☐	Hay Fever	☐	Nasal Problems	☐	Head Injury	☐
Hearing issue	☐	Glaucoma	☐	Vision Issues	☐	Mouth/dental	☐
Diabetes	☐	Eating Disorder	☐	Electrolyte issues	☐	Seizures	☐
Heart disease	☐	High/low blood pressure	☐	Skin rash	☐	Stomach issues	☐
Mood issues	☐	Hallucinations	☐	Numbness	☐	Tingling	☐
Liver disease	☐	Renal Disease	☐	Endocrine Issues	☐	Weakness	☐
Joint issues	☐	Cough	☐	Asthma	☐	Sleep apnea	☐
Menstrual irregularities	☐	Migraine	☐	Muscle	☐	Breathing problems	☐
Any significant Medical Hospitalizations:							
Any signiciant Surgical Hospitalizations:							
If yes please prescribe							

Social/Occupational History

How many friends do you have	Yes ☐ No ☐
Are you stratified with your work/school	Yes ☐ No ☐
Do You live alone?	Yes ☐ No ☐
If no, who do you live with?	
Please describes any Academic problems if any	
Please describes any Behavioral problems if any	

Drug and Alcohol history

Do you smoke?	Yes ☐ No ☐
If yes please describe	
Do you drink alcohol?	Yes ☐ No ☐
If yes please describe	
Do you use any illicit drugs?	Yes ☐ No ☐
If yes please describe	
If not currently please list dates of use	

Additional comments

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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 ☐ American Express ☐ Discover ☐ Other ☐
Name (as printed on card)	
Card Number	
Expiration Date	
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	

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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.

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 $450.00 and subsequent visits are $225.00 for 15-20 min

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.

Name	
Signature (legal guardian if indicated)	
Date	

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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.	
Signature (legal guardian if indicated)	
Date	

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND COMMUNICATIONS POLICY

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.	
I consent to receiving texts via SMS and or email for appointment reminders and consent to receive automated reminder calls.	
I have been informed that telepsychiatry appointment are available if I choose and I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.	
This consent may be revoked at any time except to the extent that information has already been released.	
Signature (legal guardian if indicated)	
Date	

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OPEN PAYMENTS DATABASE ACKNOLEGEMENT FORM

I, the undersigned individual, acknowledge that I have read the following notice as per CA Assembly Bill 1278 relating to:

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at:

https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Name:

Signature:

Date:

At your initial visit, We will conduct a thorough review of your current complaints and of your background. By the end of the initial visit We will offer our preliminary impressions, and we will discuss your treatment options. One of the most important curative aspects of a therapeutic relationship is the goodness-of-fit between a psychiatrist and client, so, the initial visit is a consultatioin and also your opportunity to determine for yourself if we are the right fit for you. If you feel that I am not well matched to your needs, we would be happy to provide you referrals to other mental health professionals.

Name:

Signature:

Date: