PSYCHIATRIC wellness center

8329 Brimhall Rd. Ste. 804
Bakersfield, CA 93312
Ph (661)431-1555 | *Fx* (661)381-7670
@ psychwellnesscenter.com

6313 Schirra Ct. Ste. 1
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Ph (661)323-6410 | *Fx* (661)323-0634
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PATIENT INTAKE INFORMATION

CONTACT INFORMATION

***Everything in BOLD must be filled-in (with blue or black ink ONLY)**

PATIENT NAME: _____ **SEX:** MALE / FEMALE

BIRTHDATE: _____/_____/_____ SOCIAL SECURITY NO: _____

HOME PHONE: _____ **CELL:** _____

HOME ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

REFERRED BY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

POLICY/ID NUMBER: _____ **GROUP NUMBER**:_____

SUBSCRIBER'S NAME: _____ **BIRTHDATE:** _____/_____/_____

RELATION TO PATIENT:_____ **SS#**: _____-_____-_____

SECONDARY INSURANCE *(if applicable)*: _____

POLICY/ID NUMBER: _____ **GROUP NUMBER**:_____

SUBSCRIBER'S NAME: _____ **BIRTHDATE:** _____/_____/_____

RELATION TO PATIENT:_____ **SS#**: _____-_____-_____

AS PATIENT, OR AS LEGAL GUARDIAN OF MINOR PATIENT, I AGREE TO PAY FOR ALL SERVICES RENDERED. THIS OFFICE MAY BILL MY INSURANCE CARRIER AS NEEDED. I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES. I AUTHORIZE THIS OFFICE TO RELEASE MY INFORMATION TO PROCESS ANY REQUESTS.

☐ For patients under 18 years of age: *I CERTIFY THAT I HAVE LEGAL GUARDIANSHIP OF THE PATIENT AND I AM AUTHORIZED TO MAKE HEALTHCARE DESCISIONS FOR THE PATIENT.*

SIGNATURE: _____ **DATE:** _____/_____/_____

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I HEARBY AUTHORIZE KERN PSYCHIATRIC HEALTH AND WELLNESS (KPHW) TO RELEASE ALL MEDICAL INFORMATION TO THE ABOVE NAMED INSURANCE CARRIER OR TO A DESIGNATED ATTORNEY FOR THE PURPOSE OF CLAIMS ADMINISTRATION AND EVALUATION UTILIZATION REVIEW AND FINANCIAL AUDIT. THIS AUTHORIZATION REMAINS VALID AND EFFECTIVE FROM THE DATE OF SIGNING UNTIL REVOKED IN WRITING.

I UNDERSTAND THAT I MAY REQUEST A COPY OF THE AUTHORIZATION.

I READ THIS AUTHORIZATION AND UNDERSTAND IT.

I HEARBY ASSIGN TO KPHW ALL MONEY TO WHICH I AM ENTITLED TO FOR MEDICAL AND/OR SURGICAL EXPENSES RELATIVE TO THE SERVICES RENDERED BY KPHW, BUT NOT TO EXTEND MY INDEBTNESS TO SAID PHYSICIAN AND/OR SURGEON.

IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE ABOVE NAMED INSURANCE COMPANY OVER AND ABOVE MY INDEBTNESS WILL BE ASSESSED TO MY ACCOUNT.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO KPHW FOR CHARGES NOT COVERED BY THIS AGREEMENT.

I FURTHUR AGREE IN THE EVENT OF NON PAYMENT TO BEAR THE COST OF COLLECTIONS AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

SIGNATURE: _____ DATE: _____/_____/_____

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TREATMENT CONSENT

I, _____authorize and request that Psychiatric Wellness Center provides treatment which is advisable in the course of my care as a patient. The frequency and type of treatment will be decided between my provider and me.

I understand that if any medication is prescribed during the course of my treatment that any risk and side effects will be explained to me at the time and that I may request to stop medication at any time. I agree to discuss the decision to discontinue medication and the possible side effects that may occur from this decision with my provider before acting upon this decision.

I understand that maximum benefit will occur with consistent attendance and compliance with treatment (medications. counseling, etc.) as suggested by my provider, but no guarantee of the results of treatment may be expected.

Important Information to Patients

Please be advised that we **do not** provide evaluations (diagnoses) or treatments for litigation purposes. Litigation purposes would include criminal cases, divorce, personal injury and emotional distress types of cases, among others. If you are seeking evaluation and treatment for a litigation purpose, we recommend that you retain a physician and/or psychologist who perform such legal evaluations and treatment.

The providers of the Psychiatric Wellness Center **do not** provide litigation evaluations or treatments; our purpose is strictly to assist YOU.

_____ I have read and fully understand this Treatment Consent form.

SIGNATURE: _____ **DATE:** _____/_____/_____

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PATIENT-PHYSICIAN ARBITRATION AGREEMENT

This Patient-Physician Arbitration Agreement, entered into between _____ ("Patient") and Kern Psychiatric Health and Wellness Center, Inc. d/b/a Psychiatric Wellness Center ("Medical Practice") and _____ ("Physician") constitutes an integral part of a contract for medical services between Patient and Physician:

1. I understand and agree that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. I voluntarily agree to submit to arbitration any and all claims arising from or relating to the medical services rendered under this agreement, including but not limited to claims for professional negligence, for premises liability, or relating to the delivery of services, whether asserted against the undersigned physician, his/her employees or the Medical Practice, irrespective of the legal theories upon which the claim is asserted.

3. I understand and agree that this Patient-Physician Arbitration Agreement binds me, my heirs, assigns or personal representative and the undersigned physician, his/her professional corporation or partnership, if any, his/her employees, partners, heirs, assigns, or personal representative, and any consenting substitute physician. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this agreement.

4. Arbitration will be in accordance with the current Health Care Claim Arbitration Rules of the American Arbitration Association. Copies of those arbitration rules are available from the Receptionist. This Agreement is for arbitration only, although mediation under the American Arbitration Association Health Care Claim Mediation Rules may be conducted if subsequently agreed to by all parties.

5. I understand and agree that a claim shall be waived and forever barred if (a) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the respondents served by the applicable statute of limitations, or (b) the arbitration hearing is not commenced within five years after the earlier of (i) the date the Demand for Arbitration was served, or (ii) the date of filing of a civil action based upon the same incident, transaction or related circumstances involved in the claim.

[SIGNATURE PAGE TO FOLLOW]

SIGNATURE: _____ **DATE:** _____/_____/_____

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NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Dated: _____ Patient: _____
(Signature)

_____
(Print name)

Psychiatric Wellness Center's Agreement to Arbitrate

In consideration of the above-named patient's promise to be bound by this Patient-Physician Arbitration Agreement, I likewise agree to be similarly bound by its terms, as set forth in this Agreement and in the Rules specified in paragraph 4 above.

KERN PSYCHIATRIC HEALTH and WELLNESS CENTER, INC. d/b/a PSYCHIATRIC WELLNESS CENTER

Dated: _____ By:_____
(As agent of Psychiatric Wellness Center)

Physician: _____
(Signature)

AGREEMENT ON BEHALF OF MINOR PATIENT-PHYSICIAN ARBITRATION AGREEMENT

I, _____ [name of responsible person], as _____ [relationship or authority to act, e.g., parent of or legal guardian] and responsible for the patient, _____ [name of patient], have read and understood the attached Patient-Physician Arbitration Agreement, including the first article and the NOTICE. On behalf of the patient, I agree to bind him or her to the attached Arbitration Agreement.

SIGNATURE: _____ DATE: _____/_____/_____

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PRACTICE GUIDELINES

The following is a list of guidelines that will allow for efficient use of your time and that of the practice's time.

Please authorize the specific practices by **initialing** in the spaces provided and signing below.

1. _____ I give permission to Psychiatric Wellness Center (PWC) to remind me by telephone of my appointments. This permission extends to allowing PWC to leave a reminder of my appointment on my message machine or voice mail.

2. _____ I give permission for the provider to use my first name in the waiting room when calling me back for my session.

3. _____ I give permission to fax any essential information to my primary physician, pharmacy, HMO, insurance provider, hospital, and/or other medical provider involved in my treatment (i.e. faxing a refill authorization to your pharmacy).

4. _____ I understand that if I am more than **10 minutes late** to an appointment the appointment will be rescheduled and a **No Show Fee** will be charged to my account, at the provider's discretion.

5. _____ I understand that if the patient is a minor (under 18 years of age), a parent, guardian or authorized person must accompany them to the appointment.

SIGNATURE: _____ **DATE:** _____/_____/_____

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MISSED APPOINTMENT AGREEMENT

***INITIALS* AND A *SIGNATURE* SIGNIFIES AN UNDERSTANDING AND AGREEMENT TO THE FOLLOWING:**

_____ It is my responsibility to notify Psychiatric Wellness Center 24 hours prior to the scheduled appointment if I intend to cancel or reschedule that appointment. We do not accept cancellations through our answering service.

_____ I will be billed for all missed appointments, late cancelations, and late rescheduled appointments at the standard office rate of $50.00 (30-45min. scheduled new evaluations), $50.00 (45-60 min. scheduled follow-ups), or $35.00 (15-30 min. scheduled follow-ups). Any missed appointments, late cancelations, and late rescheduled appointments for psychological/neuropsychological testing, two hours in length, will be charged a standard office rate of $100.00.

_____ I agree to pay this amount in the event that I miss an appointment or fail to cancel or reschedule 24 hours prior to the scheduled appointment.

_____ Payment of these abovementioned fees is required before another appointment can be made.

SIGNATURE: _____ DATE: _____/_____/_____

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Medication Compliance Contract

Patient Name: _____**Date of Birth**: _____

I, the undersigned, agree to be in compliance to all medication management appointments and treatment plans with Psychiatric Wellness Center I understand that my physician is requiring me to return as medically needed for these appointments (per his or her discretion).

1. I will take my medication as prescribed by my doctor; I will talk with my doctor before changing my dosage.
2. I will not accept the same prescriptions from any other doctors.
3. I will take care of my medications. My doctor will only replace lost, stolen or damaged prescriptions at his/her discretion, and I will be charged a $15 refill fee.
4. My doctor will only approve early refills at his/her discretion, and I will be charged a $15 refill fee.
5. My doctor will NOT approve refills when the doctor's office is closed.
6. I will request all refills by calling my pharmacy and requesting that they fax the request to the facility during doctor's office hours at least 5 days prior to taking my last dosage of medication.
7. I know that my doctor may change or stop my medication if it does not relieve my symptoms.
8. I understand that if I miss my scheduled appointment I MUST make a follow up appointment and my medications will only be refilled up to that date, and I will be charged a $15 refill fee.
9. I understand that I will be required to be seen at least every 3 months to continue services.
10. I understand that if I have not been seen in 6 months that no refills will be given and I will have to schedule a new patient appointment.
11. I understand that if my doctor prescribes a controlled substance, I will be asked to undergo occasional drug screening. A drug screen is a laboratory test in which a sample of my urine is checked to see what medications I am taking.

I understand that if this contract is broken at any time or if my physician feels that I am abusing any prescription medications, services with PWC will be discontinued immediately and a referral to another facility will be given along with a final 30 day supply of medications.

*I agree to **ALL** of the above compliances within this contract with PWC.

SIGNATURE: _____ **DATE:** _____/_____/_____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices of Psychiatric Wellness Center*** Our ***Notice of Privacy*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by writing to Psychiatric Wellness Center 8329 Brimhall Rd. Ste. 804 Bakersfield, CA 93312.

I acknowledge receipt of the ***Notice of Privacy Practices of Psychiatric Wellness Center.***

SIGNATURE: _____ DATE: _____/_____/_____

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization. This authorization expires **1 year** after the date it's signed, unless otherwise specified: _____ - _____ - _____ ***(Expiration date)***

Name of patient: _____ **Date of birth**:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize PSYCHIATRIC WELLNESS CENTER

☐ To SEND records TO: _____
Person/Organization authorized to receive the information

_____ (_____) _____ - _____
Address - street city state zip code *Phone*

☐ To RECEIVE records FROM: _____
Person/Organization authorized to receive the information

_____ (_____) _____ - _____
Address - street city state zip code *Phone*

Include the following information:

☐ **ALL** health information pertaining to my medical history, mental or physical condition and treatment:

☐ **OR** Only the following records or types of health information (including any specific date ranges):

_____

_____

I specifically authorize release of the following information (check as appropriate):

Mental Health treatment information_____ ***(Initial here)***
HIV test results_____ *(Initial here)*
Alcohol/drug treatment information_____ *(Initial here)*

**A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.*

SIGNATURE: _____ **DATE:** _____/_____/_____

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PURPOSE

Purpose of requested use or disclosure: ☐ Patient request; OR ☐ Other:_____

_____

_____

Limitations, if any: _____

_____

MY RIGHTS

*I may inspect or obtain a copy of the health information that I am disclosing by signing this form.

*I have a right to receive a copy of this authorization.

*I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:

8329 Brimhall Rd. #804 Bakersfield, CA 93312.

*Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Today's date: _____-_____-_____

_____ _____/_____/_____ (_____)_____

Patient Name *Date of birth* *Patient Telephone Number*

_____

Patient Address *City* *State* *Zip Code*

_____

Witness

SIGNATURE: _____ **DATE:** _____/_____/_____