

Please read and complete each of the sections listed below as completely as possible.

PSYCHIATRY INTAKE FORMS

- Name (First, Middle, Last): _____
- Have you ever gone by any other name? If yes, please specify:

- Date of birth: _____ Sex: M / F Marital Status: _____
- Street Address: _____
City: _____ State: _____ Zip: _____
- SSN: - - Email address: _____
- Phone Numbers (Please check the box if able to leave a detailed message):
 Home: _____ Work: _____ Cell: _____

Medical and Referral Information

Name of Primary Care Physician: _____

Telephone Number of Primary Care Physician: _____

Address of Primary Care Physician: _____

May I contact your health care provider in the future? Yes No

Who referred you to our practice? _____

Please list names and contact information for any doctors and/or therapists that have been significantly involved in your care over the last ten years.

Emergency Contact

Who should we contact in case of emergency? _____

Relationship to you? _____ Phone number _____

Medical History

Current medical problems (please include date of onset):

Past medical problems and/or surgical history (with dates):

Family Medical/Mental Health/Drug/Alcohol History (siblings, parents, children, aunts/uncles):

Current medications (name/dosage/frequency/reason for taking the medication):

- _____
- _____
- _____

Past psychiatric medications (name/dosage/frequency/reason for taking the medication):

- _____
- _____

Allergies to medications and reaction: _____

Supplements, vitamins, or herbs: _____

Drug or alcohol use (include amount and frequency): _____

Do you currently use tobacco: Yes No If yes, how long?: _____

Have you ever used tobacco in the past? Yes No If yes, please specify: _____

Exercise (frequency & type): _____

Presenting Issues:

Symptoms and duration: _____

**Authorization to Release Patient Health Information for Treatment,
Billing, or Healthcare Operations**

I understand that Vista Mental Health reserves the right to change their notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing. I understand that the Vista Mental Health staff are not required to adhere to these restrictions requested in the event of a potentially life threatening emergency.

Records may be needed in order to process a claim for medical services. I authorize providers at Vista Mental Health to release information needed for billing purposes to entities that may provide services pertaining to my physical visit, such as laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of billing, treatment, or pertinent healthcare operations.

Patient/Guardian Signature _____

Date _____

Patient/Guardian Printed Name _____

I authorize Vista Mental Health to discuss my psychiatric/mental health care to any and all past or present treating health professionals as well as the following (*please list* any friends or family members that you may want to have included in your treatment):

I am aware that this information may pertain to my psychiatric condition and/or treatment of substance abuse. I execute the release of this information.

Patient/Guardian Printed Name Signature _____

Date _____

Patient/Guardian Printed Name _____

Notice of Office Policies and Procedures and Consent of Treatment

Privacy and Release of Information

Services that you receive in this office are confidential, except in the following circumstances listed below:

- Threats of harm to yourself or others
- Abuse of a vulnerable adult, child, or developmentally disabled person
- A court order to release information
- Subpoena of treatment records by an attorney. If you do not want this information released, you must obtain a protective order from the court within fourteen days of the request.
- If you will be submitting a claim to your health insurance, we may be required to prove information to your health plan, including some or all of your record of treatment, in order for your carrier to pay for services. By signing this form, you consent to release this information to your health plan.
- If you are involved in a child custody litigation at any time in the future, the court may order release of information about your treatment

In circumstances other than these, I will not release information about your treatment without your authorization.

Patient Records

A secured electronic record is kept of services you receive in this office. You have the right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize, in writing, that copies of the record be released to entities you designate. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider.

Methods of Communication and Execution of Clinical Care

You can generally expect a return call within one business day that a message is left. Should there be an emergency or concern for imminent health or the safety of yourself or another person, please call 911 or go to the nearest emergency room immediately.

Hospitalization

Should you require hospitalization, please go to your nearest emergency room or dial 911. Staff at Vista Mental Health do not have admitting privileges at the hospital. Should you need to be admitted, they can communicate with the inpatient treatment team to let them know about your prior treatment.

Travelling Out of State:

Should you leave the state, your provider will not be able to continue to prescribe medication. If you are going on vacation, please call your provider with enough notice so that he or she can give you enough medication prior to your trip.

Secure Messaging:

Patients are offered the opportunity to use secure messaging (similar to email) with providers through patient fusion. Should a patient elect to do this, please keep in mind that this service should only be used for non-emergent matters as messages are not checked daily. This service is HIPAA compliant.

Should there be an emergency, the best option is call 911 or go to the nearest emergency room.

Patient/Guardian Signature_____

Date_____

Patient/Guardian Printed Name_____

Telepsychiatry:

Providers can use video conferencing to see patients, should that be the best option for the patient. Please keep in mind that this is up to the discretion of the provider. This is typically only used for patients that are stable on their current medication regimen. In addition, controlled substances cannot be called into pharmacies, so should those medications be part of the treatment plan, the patient would need to be seen in person. Also, please note that if you plan to submit your superbill to your insurance company for reimbursement, they may not reimburse as much as they would if you were seen in the office.

Patient/Guardian Signature_____

Date_____

Patient/Guardian Printed Name_____

Consent for email/text messages

I understand that Vista Mental Health cannot guarantee the confidentiality of any email communications and will not be liable for improper disclosure of confidential information and/or breaches in confidentiality caused by me or a third party. I understand that Vista Mental Health has no control over the security or management of my individual email service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient. I further understand and agree that: email will not be used in emergencies and I agree to call 911 in the event of an emergency, emails will be answered within a maximum of 7 business days and that a prompt reply may not be available during weekends or holidays, I must include my full name and date of birth in every email message I send, I understand and agree that providers may choose to stop electronic communications with me at any time, and I understand that the confidentiality of my individually identifiable health information may be compromised when such is sent through email. I agree to the requirements listed above and hereby voluntarily request and consent to communicate with physician and/or office personnel by email or text.

Patient/Guardian Signature_____

Date_____

Patient/Guardian Name_____

Notice of Open Payments

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>.

Patient/Guardian Signature _____

Date _____

Patient/Guardian Printed Name _____

Notice and Acknowledgment of Receipt and understandings

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to
www.mbc.ca.gov,
email: licensecheck@mbc.ca.gov,
or call (800) 633-2322

Date

Patient's Name (Type or Print)

Patient's Signature

Insurance Benefits and Patient Responsibilities for Fees

We do not participate as a contracted provider for any insurance company, but can provide you with a detailed receipt called a superbill that you may submit to your insurance company. They may or may not provide some direct reimbursement to you. Payment is due at the time the service is rendered. Fees are reevaluated annually and may increase by up to 5% per year. We accept cash, check, and major credit cards. It is required that a credit card be kept on file. This card will be charged the **full fee for failure to keep any scheduled appointments without 24 hours prior notification** (or **one business day**- so in the case of weekends and holidays, cancellations will need to be made more than 24 hours in advance) and will also be used when billing for phone calls. Phone calls longer than ten minutes may be charged as a full session. Any outstanding fees will be charged to the card designated on this form.

Fee Agreement

CPT	DESCRIPTION OF PROCEDURE	MINUTES	FEE
90792	Diagnostic Evaluation	60	\$495
90792	Complex Diagnostic Evaluation	90	\$725
99213 – 99215	Psychotherapy with Medication Management	50	\$385
99213 – 99215	Medication Management	25	\$255
90833, 90836, 90838	Psychotherapy add on codes, 30, 45, and 60 min		

Forms/letters: \$50-\$200 (Variable/time dependent) Insufficient funds/returned check fee: \$50

I understand and accept the terms of the charges, cancellation fees, insufficient funds/ returned check fees and no-show policy as outlined above and authorize Vista Mental Health (or Dr. Deborah Fein Medical Corp) to charge my credit card or checking account accordingly.

Name on Card: _____
Card # _____
Expiration date: _____ Security code: _____

OR

Name on account: _____
Account#: _____ Routing#: _____
Phone number associated with account: _____

Billing street address: _____

City: _____ State: _____ Zip: _____

Signature: _____

Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as the 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 up 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.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liabilities and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

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.

By: _____
Physician's or Duly Authorized Representative Signature (Date)

By: _____
Patient's Signature (Date)

By: _____
Print of Stamp Name of Physician, Medical Group or Association Name (Date)

By: _____
Patient's Name (Date)

By: _____
Signature of Translator (if applicable) (Date)

By: _____
Patient's Representative's Signature (If applicable) (Date)

Print Name of Translator

Print Name and Relationship to Patient