Harbor Psychologist, Inc.

New Patient Information and Consent

Form to be completed by patient (or parent/ guardian if patient is under age 18)
All Information MUST be completed

Patient Name:____________________ **Today's Date:**__________

Date of Birth:__________ **Age:**_____ **Male**☐ **Female**☐ **Social Security #:** __________

Address:______________________________

City: _______________ **State:**_______ **Zip Code:** ____________

Phone- Home:__________ **Work:**__________ **Cell:**__________

May we call your home? Yes☐ No ☐ May we call your work? Yes ☐ No☐ **May we call your cell?** Yes☐ No☐

May we email you? Yes No **May we text your cell?** Yes☐ No☐

Email:____________________ **Referred by:**____________________

Marital Status: Single ☐ Living Together ☐ Married ☐ Partners ☐ Separated ☐ Divorced☐ Widowed ☐

Employer/School:_______________ **Occupation**:_______________

Financial Responsibility (insured person, person responsible for payment)

Insured's Name:_______________ **Insured's Social Security #:**__________

Insured's Date of Birth:__________ **Relationship to patient**:_______________

Address (if different than patient) ____________________

City: _______________ **State**:_______ **Zip Code**: ____________

Contact Phone Number (if different than the patient) _______________

Insurance Company: _______________ **Phone #** _______________

Member ID# on Insurance Card:__________ **Group #:**__________ **Policy:**__________

Mental Health Carrier:_______________ **Mental Health Phone #:** _______________

Initial Authorization #:_______________ **Employer:**_______________

Secondary Insurance Company:_______________ **Phone #** _______________

Insured's Name:__________ **SS#:**__________ **Group:**__________

Person to Contact in Case of Emergency

Name:_______________ **Relationship to Patient:** _______________

Home Phone: __________ **Work:** __________ **Cell:** __________

Harbor Psychologist, Inc.

MEDICAL HISTORY

Primary Care Physician: ___________________________________ Phone Number: _____________________________

Date Last Seen: ________________________ Reason for Last Visit: ____

____

Please list any medications you are currently taking: ____

____

____

Please list any past or present medical conditions for which you have been treated:______________________________

____

____

____

Presenting Problem(s) - Please describe your reason for seeking treatment at this time and include when the problem started: ____

____

____

____

____

Was there an event which caused these problems? Yes ☐ No ☐

If Yes please explain:____

____

____

____

Allergies: ☐**Yes** ☐**NKA (No Known Allergies)**

If Yes Please List Them: ____

____

____

____

Harbor Psychologist, Inc.

Please read and individually acknowledge each section by initialing on the line to the left, and sign at the bottom

_____ **Financial Terms and Assignment of Benefits**

Upon verification of insurance coverage and policy limits, your insurance will be billed for you and your provider will be paid directly by the carrier. Upon acceptance of your appointment it will be the patient's responsibility for any and all fees. Payment is due at the time services are rendered. If you are without insurance coverage, payment arrangements should be made prior to your first appointment.

_____ **Canceled / Missed Appointments**

When scheduling an appointment, a time is set aside specifically for you. If you cancel or do not keep your appointment without giving 48 hour notice – or by Friday at noon for a Monday appointment, you will be charged $70. If two appointments are cancelled or missed consecutively, you may be in non-compliance and may be referred back to your insurance company to find a new provider.

_____ **Appeals and Grievances**

You have the right to request reconsideration in the case that outpatient care (number of visits) is not authorized. This is called an appeal. You can request and appeal though your provider. You have the right to submit a Grievance directly to your provider or to the Clinical Group to which they belong at any time that you have a complaint about any aspect of your care. If you are not satisfied with the response you receive, you may submit the Grievance to your health plan directly.

_____ **Emergencies**

If you are in imminent danger call 911, your nearest police department or go to a hospital emergency room. For all other emergencies please call the Los Angeles County Crisis Line at 800-854-7771.

_____ **Confidentiality**

All information between therapist/ Doctor and patient is held strictly confidential unless:

You authorize release of information with your signature (or parent/ guardian)

You present a physical danger to self

You present a physical danger to another

Child, elder or disabled individual abuse is suspected

In the latter two cases, we are required by law to inform potential victims and legal authorities so protective measures can be taken. The Notice of Privacy Practices is being provided as required by HIPPA. You may request a paper copy at any time.

_____ **Consent for Treatment**

"I authorize and request that my Provider(s) carry out psychological examinations, treatments and/ or diagnostic procedures, now and during my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult and uncomfortable."

_____ **Release of Information to my Insurance Company**

"I authorize the release of information for claims, certification/ case management, and other purposes related to the benefits of my Health Plan."

I understand and agree to all of the above information.

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices and that I have read and understand all of the above information.

Signature of Client (Parent or Guardian if Client is a minor)	Date	Provider signature

Harbor Psychologist, Inc.

4010 Watson Plaza Drive Suite 285, Lakewood, CA. 90712 (562)497-1505 Fax (562)497-1881

Behavioral Health / PCP Coordination of Care Form

Coordination of Care Form PCP Office: Please place copy of form in patients chart. This form is intended to coordinate care with primary physicians and medical specialists. This is not intended to replace the agency's existing release of information form.

Primary Care Physician, Provider or clinic: ____

Phone number ______________________ Fax ___________________________

Street Address ____

City _______________________________ State__________ Zip ___________

Patient Information

Name: _____________________________ DOB: ________________ Date of Evaluation: ______________________

Reason for referral: Risks, Concerns, (homicidal/suicidal ideation, etc.)

____

____

Diagnoses: ____________________ Medications Currently prescribed: (including herbal)

____

Treatment Plan or recommendations:

____

Medical follow-up recommended:

____

____

Treating Behavioral Health Provider: _____________________________________ Date Sent: ___________________

Patient Rights:
You can end this authorization at any time. If you make a request to end this authorization, it will not include information that has already been used for disclosed based on your previous consent. You cannot be required to sign this form as a condition of treatment or payment. Information disclosed as a result of this Authorization Form may be re-disclosed by the recipient and is no longer protected by law. You do not have to agree to this request to use or disclose your information.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire six months from the date of my signature, unless another date is specified. I have read and understand the above and give my authorization:

☐ To release any applicable mental health/substance abuse information to my medical provider

☐ To release only medication information to my medical provider

☐ I DO NOT give my authorization to release any information to my medical provider.

Patient Signature:____ Date: ______________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.