INLAND PSYCHIATRIC MEDICAL GROUP, INC

PATIENT INFORMATION SHEET

PLEASE PRINT

PATIENT'S NAME _____ **DOB** _____
LAST FIRST MI

LANGUAGE _____ **SEX** ❑ **M** ❑ **F** ❑ **Minor** ❑ **Married** ❑ **Single** ❑ **Divorced** ❑ **Widowed**

RACE _____**RELIGION** _____ **ETHNICITY** _____

HOME PHONE ( ) _____ **Cell ( )** _____

(NOTE: MARK THE PHONE NUMBER PERMITTED TO LEAVE MESSAGES / APPT REMINDERS WITH A *)

STREET ADDRESS _____

CITY/STATE/ZIP _____

WHOM SHOULD WE THANK FOR YOUR REFERRAL? _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE NAME_____ **ID** _____

PRIMARY SUBSCRIBER ❑ **Self** ❑ **Spouse** ❑ **Parent** ❑ **Other** _____

D.O.B._____**GROUP#** _____**C.D.L.#** _____

EMPLOYER'S NAME _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE NAME_____ **ID** _____

SECONDARY SUBSCRIBER ❑ **Self** ❑ **Spouse** ❑ **Parent** ❑ **Other** _____

D.O.B._____**GROUP#** _____**C.D.L.#** _____

EMPLOYER'S NAME _____

--EMERGENCY CONTACT--

INFORMATION ON NEAREST RELATIVE OR FRIEND

NAME _____**PHONE#** _____

ADDRESS: _____

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE _____

INLAND PSYCHIATRIC MEDICAL GROUP, INC

FINANCIAL POLICY

Please understand that payment of your bill is considered a part of your treatment. IPMG will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Co-payment amounts may vary during the course of treatment, as outlined by your plan. Co-payments are due and payable at each appointment. The co-payment amount set by your plan for each visit is as follows:

1-5 visits ____ 6-10 visits ____ 11-20 visits ____ 21-25 visits ____ 26-50 visits ____

_____

If at any time during your treatment you become ineligible for coverage by your insurance, you will be responsible for 100% of your bill. 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.

Minor Patients:
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.

Missed Appointments: Effective December 1, 2003
Unless canceled, at least 24 hours in advance, there will be a $65.00 charge for missed appointments. Emergency situations will be considered. Please help us serve you better by keeping scheduled appointments.

Miscellaneous Fees:
There will be a charge of

$10.00 per page for all forms requiring completion
$25.00 for all disability paperwork
$65.00 Late cancellation/ no show fee (appointments)
$30.00 Medical Records
$50.00 Letter writing
$500.00 Court Appearances

Please sign below indicating your understanding of IPMG's financial policy:

Patient or Guardian's Signature _____ Date _____

INLAND PSYCHIATRIC MEDICAL GROUP, INC

Consumer Notice of Rights and Responsibilities

Dignity and Respect

- You have the right to be treated with consideration, dignity and respect – and the responsibility – to respect the rights, property and environment of all physicians and other health care professionals, employees and other patients.
- You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational or religious background.

Knowledge and Information

- You have the right to receive information about the organization's services and practitioners, clinical guidelines, and member's right and responsibilities.
- You have the right – and the responsibility – to know about and understand your health care and your coverage, including:
  - Participating with your physician and other healthcare professionals in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
  - The names and titles of all health care professionals involved in your treatment.
  - Your clinical condition and health status.
  - Any services and procedures involved in your recommended course of treatment.
  - Any continuing health care requirements following your discharge from a provider's office, hospital, or treatment program.
  - How your health plan operates – as stated in your Policy and/or Certificate.
  - The medications prescribed for your – what they are for, how to take them properly and possible side effects.

Continuous Improvement

- As a partner with your health plan and any health care professional who may be involved in your care, you have the right to:
  - Contact a Member Service Associate to address all questions and concerns as well as to make suggestions for improvement to the health plan and/or the members' rights and responsibilities policies.
  - Ask questions about any clinical advice or prescribed treatment if you need an explanation or want more information.
  - Appeal any unfavorable behavioral health care decisions by following the established appeal or grievance procedures of your health plan.

Eligible Employee
Accountability/Autonomy

- As a partner in your own health care, you have the right to refuse treatment – providing you accept responsibility and the consequences of such a decision—and the right to refuse to participate in any medical research projects.
- You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals.
- You also have the responsibility to:
  - If you have PacifiCare Insurance identify yourself as such when receiving behavioral health services.
  - Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved in the course of your treatment.
  - Be on time for all appointments and to notify your provider's office as far in advance as possible if your need to cancel or reschedule an appointment.
  - Receive all non-emergent or urgent care through your assigned behavioral health provider and obtain preauthorization of service from Managed Care Company, if applicable.
  - Notify your behavioral health plan within 48 hours – or as soon as possible—if your are hospitalized or receive emergency care.
  - Pay all required co-payments and deductibles at the time you receive behavioral health care services.
- You have the right at any and all times to contact a member service associate for assistance with issues regarding your behavioral health plan.
- It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care.

If you have any questions or complaints regarding your rights, contact the Member Service Associated with your insurance company. (If you are a PacifiCare member call (800) 999-9585.)

Patient or Guardian's Signature _____ Date _____

Therapist Signature _____ Date _____

INLAND PSYCHIATRIC MEDICAL GROUP, INC

Mental Health Disclosure Form

Treatment Philosophy-Explanation of Brief Therapy

- Brief therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask. **Initial here:_____**

Limits of Confidentiality Statement

- All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:
  1. The patient authorizes a release of information with a signature.
  2. The patient's mental condition becomes an issue in a lawsuit.
  3. The patient presents as a physical danger to self (*Johnson v County of Los Angeles, 1983*).
  4. The patient presents as a danger to others (*Tarasoff v Regents of University of California, 1967*).
  5. Child or Elder abuse and/or neglect are suspected (*Welfare & Institution and/or Penal Code*).

  In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

- All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion is not to be discussed outside of the counseling sessions. **Initial here:_____**

Release of Information

- I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis,, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. **Initial here:_____**

Emergency Access

- Practitioners are available after hours to handle emergencies. By calling the main office number during after hours, you will be instructed how to contact the on-call practitioner. **Initial here:_____**

Consent for Treatment

- I authorize and request my practitioner carry out psychological exams, treatment and /or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me..
  Initial here:_____

_____ _____
Patient/Guardian Signature Date

_____ _____
Practitioner Signature Date

General Consent for Child or Dependent Treatment

- I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ _____
Patient Name Patient Social Security Number

_____ _____
Signature of Legal Guardian/Legal Representative Date

_____ _____
Relationship to Patient Benefit Plan Subscriber Name

_____
Mental Health Benefit Plan

_____ _____
Practitioner Date

INLAND PSYCHIATRIC MEDICAL GROUP, INC

ASSIGNMENT OF BENEFITS

Authorization To Pay Benefits To Provider

I hereby authorize payment directly to the Provider of service for mental health benefits, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services.

_____

Signature of Patient, Legal Guardian/Legal Representative

_____

Name (Printed)

_____

Relationship to Patient

_____

Patient Name (if different from that above)

_____

Date

INLAND PSYCHIATRIC MEDICAL GROUP, INC
APPEALS AND GRIEVANCES

Appeals Process

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient visits are denied certification by Inland Psychiatric Medical Group, Inc. I understand that I would request an Appeal through my Therapist and that I risk nothing in exercising this right. I understand that my Therapist may initiate the appeal process by submitting a letter and any pertinent documentation within 30 days of the denial to my insurance company. (If you are a PacifiCare member contact PacifiCare Behavioral Health of California, Inc., Customer Service Department, 23046 Avenida de la Carlota, Suite 700, Laguna Hills, CA 92653

Grievances

I also understand that I may submit a complaint or Grievance to my managed care company at any time to register a complaint about my care. I am aware that I may contact the Member Service Department (number listed on your insurance ID card. (If you are a PacifiCare member the number is **(800)-999-9586.**
I understand that the California Department of Corporations (DOC) is responsible for regulating health care services. The California DOC has a toll-free telephone number **(800-400-0815)** to receive complaints regarding health care plans. (If I have a grievance against PBHC I can contact PBHC and use the appeal and grievance process.) If I need the DOC's help with a complaint involving an emergency appeal or with an appeal that has not been satisfactorily resolved by the plan, I can call the DOC's toll free telephone number.

_____
Signature of Patient, Legal Guardian/Legal Representative

_____
Name (Printed)

_____
Relationship to Patient

_____
Patient Name (if different from that above)

_____
Date

INLAND PSYCHIATRIC MEDICAL GROUP, INC

PATIENT ACKNOWLEDGEMENT of
NOTICE OF PRIVACY PRACTICES

I, _____ have received
Patient Name (Please Print)

the **Notice of Privacy Practices,** and understand that Inland Psychiatric Medical Group, Inc. has certain legal duties to safeguard my Protected Health Information. (PHI). I also understand that I have certain rights in regard to my (PHI).

_____ _____
Signature Date

INLAND PSYCHIATRIC MEDICAL GROUP, INC

HEALTH CARE COORDINATION FORM

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

PATIENT NAME: _____ DOB: _____

MEMBER ID NUMBER OR SOCIAL SECURITY NUMBER: _____

I hereby authorize the release of the medical information listed below which pertains to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and /or substance abuse diagnosis and treatment to my primary care physician:

_____

Primary Care Physician Name

_____

Address

_____

Phone Number **Fax Number**

I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care, which I may receive from specialists. I further understand that I have a right to receive a copy of this authorization upon my request. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to this recipient only with signed consent from me.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

Dear Dr. _____ I wish to inform you that your patient _____

was referred to me for treatment on ____/____/____. Please review the following for coordination of care

DX: Axis I (Primary Dx) _____

Axis I (Secondary Dx) _____

Recommendations:

Therapy: individual/family/group/couple or Medication management

Labs: None, TSH Free T4, Comprehensive Metabolic Panel, Urinalysis, Basic Urine Drug Screen w/ Alcohol, CBC with Diff, Vitamin B12, Folate Level, PSA Level, Testosterone Level, Lithium Level, Depakote Level, Lipid Panel Fasting, BHCG Urine Pregnancy, Other _____

Medications: _____

_____

Clinician Name: _____ Signature: _____

If you need additional information, contact me at:

- ❑ 1809 W. Redlands Blvd. Redlands, CA 92373 P: 909-335-3026 F: 909-335-3167
- ❑ 8710 Monroe Court, Ste. 150 Rancho Cucamonga, CA 91730 P: 909-941-4870 F: 909-941-4875
- ❑ 540 W. Baseline, Ste. 3, Claremont, CA 91711 P: 909-625-7175 F: 909-625-7268
- ❑ 1080 N. Indian Canyon Road, Ste. 206, Palm Springs, CA 92262 P: 760-322-4400 F: 760-327-8923
- ❑ 16279 Walnut St., Hesperia, CA 92345-3622 P: 760-947-0070 F: 760-947-3494
- ❑ 11800 Central Ave Suite #223,Chino, CA 91710-7200 P: (909) 902-1082 F: (909) 628-3983

INLAND PSYCHIATRIC MEDICAL GROUP, INC

SYMPTOMS IDENTIFICATION and HEALTH HISTORY

PATIENT'S NAME _____

Please state your presenting problem(s) and the length of time you have experienced it/them: _____

_____

_____

Please take a few minutes to complete the following. Severity 0 meaning <u>not present</u> through 4 meaning <u>severe problem</u>

SYMPTOM	← NONE		–		SEVERE →
Crying spells	0	1	2	3	4
Extreme tiredness	0	1	2	3	4
Feelings of dread	0	1	2	3	4
Feelings of hopeless / helpless	0	1	2	3	4
Headaches	0	1	2	3	4
Hearing voices	0	1	2	3	4
Impulse control problems	0	1	2	3	4
Loss of appetite	0	1	2	3	4
Loss of interest in activities	0	1	2	3	4
Loss of interest in sex	0	1	2	3	4
Nervousness	0	1	2	3	4
Feeling helpless / hopeless	0	1	2	3	4

SYMPTOM	← NONE		–		SEVERE →
Nightmares	0	1	2	3	4
Panic attacks	0	1	2	3	4
Poor concentration	0	1	2	3	4
Poor memory	0	1	2	3	4
Sadness	0	1	2	3	4
Sleep Problems	0	1	2	3	4
Suicidal thoughts & plans	0	1	2	3	4
Suspiciousness	0	1	2	3	4
Weight loss	0	1	2	3	4
Worry all the time	0	1	2	3	4
Others (Please write)	0	1	2	3	4
	0	1	2	3	4

ALLERGIES? ☐ YES ☐ NO IF YES LIST _____, _____, _____

HEALTH HISTORY ☐ BP ☐ DIABETIC ☐ ASTHMA ☐ CORONARY ☐ SURGICAL ☐ _____

PAST PSYCH HISTORY ☐ YES ☐ NO _____ **HOSPITALIZATIONS ☐ YES ☐ NO** ____ **TIMES**

EVER HAD THOUGHTS OF SUICIDE ☐ YES ☐ NO HOMICIDE ☐ YES ☐ NO ☐ PAST ☐ PRESENT ☐ FAMILY

FAMILY PSYCH HISTORY ☐ YES ☐ NO IF YES WHO _____**WHAT**_____

ARE YOU TAKNG ANY MEDS? ☐ YES ☐ NO PRESCRIBER _____

_____ **HEIGHT** _____**FT** _____**IN WEIGHT** _____**LBS**

DO YOU USE ANY OF THE FOLLOWING? ANSWER SPECIFICS FREQUENCY, QUANTITY, FORM OF USE, START AGE / FOR HOW LONG, IF SOBER FOR HOW LONG AND RELAPSE REASONS IF ANY, ETC.

CAFFINE ☐ YES ☐ NO _____

SMOKE ☐ YES ☐ NO ☐ NEVER ☐ PASSIVE_____

TOBACCO ☐ YES ☐ NO ☐ NEVER_____

ALCOHOL ☐ YES ☐ NO ☐ NEVER _____

DRUGS ☐ YES ☐ NO ☐ NEVER _____

FAMILY HISTORY: DRUGS ☐ YES ☐ NO WHO _____ **ALCOHOL ☐ YES ☐ NO WHO** _____

PHARMACY NAME _____ **PHONE** _____

CROSS STREETS/ADDRESS_____ **CITY**_____