Minor Packet w/consent

1. **Please enter patient's information.**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender Identity:

_____

Ethnicity

_____

Race

☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White ☐ Other ☐ Decline to Specify

Phone Type _____ Phone Number _____ Email: _____

Phone Type
○ Home ○ Mobile ○ Work

Secondary Phone

_____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Street Address:

_____

Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

2. **Please enter your pharmacy information below**

Pharmacy Name (must be located in California)

_____

Pharmacy Address

_____

Pharmacy Phone

_____

Pharmacy Fax

_____

3. **Emergency Contact**

Relationship to Contact

_____

First Name

_____

Middle Name

_____

Last Name

_____

Phone Type

_____

Phone Number

_____

Address Line 1

_____

Address Line 2

_____

City | State | Zip

4. Primary Insurance

Primary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Street Address

5. Please upload front and back pictures of your insurance card

6. Please state the patient's presenting problems

7. **Please take a few minutes to complete the following. Check the number that applies to you. The numbers range from 0 meaning not present through 4 meaning severe problem**

Symptom	None	Mild	Moderate	Severe
Crying spells				
Extreme tiredness				
Feelings of dread				
Feeling hopeless / helpless				
Headaches				
Hearing voices				
Impulse control problems				
Loss of appetite				
Loss of interest in activities				
Loss of interest in sex				
Nervousness				
Nightmares				
Panic attacks				
Poor concentration				
Poor memory				
Sadness				
Sleep Problems				
Suicidal thoughts or plans				
Suspiciousness				
Weight loss				
Worry all the time				

Other Symptoms?

_____

8. **Medical History Please fill the following in detail using the other option for the conditions not listed. Please type N/A where needed.**

1. Height _____

2. Weight _____

3. Allergies?
○ YES ○ NO

If yes, specify the type of reaction and severity?

_____

_____

4. Medical History (required)

☐ Head trauma ☐ Anemia
☐ Arthritis/GOUT
☐ sleep apnea
☐ Skin conditions ☐ Cancer
☐ HIV/AIDS

Heart conditions

☐ High blood pressure
☐ Arrhythmias
☐ Congestive heart failure
☐ Heart attack ☐ Other

Gastrointestinal

☐ GERD ☐ Ulcers ☐ Heart burn
☐ Gallbladder disease ☐ IBS
☐ Ulcerative colitis/Crohn's
☐ Other

Endocrine

☐ Thyroid problem
☐ High cholesterol
☐ Diabetes type 1/type 2
☐ Lupus ☐ Other

Neurological

☐ Seizures ☐ Stroke
☐ Migraines ☐ Other

Respiratory

☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ COPD
☐ Other

Genitourinary

☐ Kidney stones
☐ Kidney failure ☐ UTI ☐ STD'S
☐ Other

Other Medical problems

_____

_____

5. Medical Hospitalization

○ Yes ○ No

6. Surgeries:

_____

_____

7. Past Psych History?

○ Medication management ○ Therapy/Counselling ○ Intensive outpatient program
○ Drug detox/rehab ○ ECT ○ rTMS ○ N/A

Please mention if patient/child has received past psychiatric medications. Please mention medication name along with any side effects if present.

_____

_____

Psychiatric Hospitalization?

○ Yes ○ No

If Yes, Please state number of times including when and where?

_____

_____

Any past suicide attempts? If yes, please state number of times including when and where?

_____

_____

Please mention if there is any family history of psychiatric illness/substance use/suicide. If yes, please detail who and what.

_____

_____

History of physical/sexual abuse/trauma

○ Yes ○ No

Is patient a current smoker/heavy alcohol user? Are you interested in receiving couseling/treatment for smoking cessation/alcohol use?

_____

9. Which medications (psychotropic or not) are you currently taking?

	Medication	Dosage	Since when?	Adverse effects
1				
2				
3				
4				
5				

10. Does patient use any of the following? Answer specific frequency, quantity, form of use, start age / for how long, if sober for how long and relapse reasons if any, etc.

Caffeine
○ Yes ○ No

Smoke
○ Yes ○ No
○ Never
○ Passive

Tobacco
○ Yes ○ No
○ Never

Alcohol
○ Yes ○ No
○ Never

Drugs
○ Yes ○ No
○ Never

Family History of Drugs
○ Yes ○ No

Who

Family History of Alcohol
○ Yes ○ No

Who

11. Developmental History

Were there any complications at the time of delivery or after? If “yes” please elaborate, if "no" please answer N/A, if unsure please answer "I don't know"

Was the pregnancy pretermed or termed?

Were any medications prescribed/taken during this pregnancy? If “yes” please elaborate, if "no" please answer N/A, if unsure please answer "I don't know"

Did the child’s biological mother engage in tobacco/alcohol/marijuana/or other drug use during the pregnancy? If “yes” please elaborate, if "no" please answer N/A, if unsure please answer "I don't know"

12. Developmental History (Continued) Please answer yes or no if there was a delay in child milestones. If yes, was any intervention done?

	Yes	No
Crawling		
Walking		
Talking		
Toilet Training		

If "yes", was any intervention done?

13. Developmental History (Continued) If any of the following questions are not applicable, please answer N/A

Was the child adopted?

If so from where?

At what age was the child adopted?

What are any significant stressors or traumas to the family and child?

Has your child ever been hospitalized? If so, please explain when and for what reason.

Has this child ever been exposed to abuse? Please state whether it is/was physical, emotional or sexual and whether he was the object to the abuse or exposed to it.

Is there anything else I should know about your child's development or developmental history?

14. Education History If any of the following questions are not applicable, please answer N/A

Where is your child attending school now?

What grade?

If it is an ungraded class, state approximate grade achieved

If the child is not enrolled, name last school attended, grade achieved, date withdrawn.

Has your child been held back or skipped a grade? Please explain.

Has the child been identified for special education, learning support or emotional support? Please state year identification and provisions made.

Describe your child's behavior in school.

Has your child been tested for Learning Disabilities? If "yes", please describe the results.

Is there anything else I should know about your child's school history?

15. CAGE-AID

Patient Name

Date

Have you felt you ought to cut down on your drinking or drug use?
○ Yes ○ No

Have people annoyed you by criticizing your drinking or drug use?
○ Yes ○ No

Have you felt bad or guilty about your drinking or drug use?
○ Yes ○ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?
○ Yes ○ No

Are you a current smoker?
○ Yes ○ No

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.

Name

Relationship to Patient

Patient Name (if different from above)

Patient or Parent/LegalGuardian Signature

Date

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 IEHP 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 an IEHP member call (800) 440-4347.)

Client Signature

Date

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.

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.

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. **IEHP members may contact (800) 440-4347**.

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.

Client Signature

Date

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. 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.

Miscellaneous Fees:

There will be a charge of

$10.00 per page for all forms requiring completion

$25.00-50.00 for disability paperwork

$65.00 late cancellation/ no show fee (appointments)

$15.00 Medical Records

$50.00 Letter writing

Court/legal appearances may vary by provider. Please contact office for fee schedule.

I understands that there will be a $65.00 charge for cancelling the appointment without a 24 hour notice or appointments that result in a no show. However after three no show or late cancellation appointments patient will be referred back to insurance, due to a high volume of no show and late cancellations. Urgent cancellations will be taken into consideration.

_____ _____

Client Signature Date

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 Provider and that I risk nothing in exercising this right. I understand that my Provider may initiate the appeal process by submitting a letter and any pertinent documentation within 30 days of the denial to my insurance company.

_____

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 an IEHP member the number is (800) 440-4347.)**

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)** 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.

_____

Name _____ Relationship to Patient _____

Patient Name (If different from above) _____

_____ _____

Client Signature Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

Patient Name: _____ DOB: _____ Date _____

Member ID Number or Social Security Number: _____

With your consent, we may release the medical information listed below which pertains to your 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 your primary care physician

Please Choose one of the Following:

○ Yes, I authorize release ○ No, I do not authorize release

If Yes:

Name of Primary Care Physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

Name of your current Therapist/Counselor (Type N/A if not applicable):

_____

Address: _____

Phone Number: _____ Fax Number: _____

Name of your current Specialist (Ex: Cardiologist, OB-GYN, Endocrinologist):

_____

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.

_____ _____

Client Signature Date

NOTICE OF PRIVACY PRACTICES

INLAND PSYCHIATRIC MEDICAL GROUP, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. 3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your

information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. ***[Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate***

with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. [Optional: Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,

We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent

that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.] [*Add the following three activities, or any of the three, only if the organization engages or intends to engage in these activities.*]

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

24. Fundraising. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further

fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. 3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an

incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. **[*For practices with websites add*: We will also post the current notice on our website.]**

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX

Office for Civil Rights

U.S. Department of Health & Human Services

90 7th Street, Suite 4-100

San Francisco, CA 94103

(415) 437-8310; (415) 437-8311 (TDD)

(415) 437-8329 FAX

OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

I have received 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). Notice: Forms will be available to download at the end of the intake process and additional copies will be available at the office locations.

Patient Signature

Date

Telemedicine Consent Form

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. (*name of Physician*) has explained the alternatives to my satisfaction,

5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform (*name of Physician*) of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of California and will be present in the state of California during all telehealth encounters with (*name of Physician*).

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize my Physician to use telemedicine in the course of my diagnosis and treatment.

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Date of Consent _____

_____ _____

Patient Signature Date

Name _____ Date _____

Over the last 2 weeks, how often have you been bothered by any of the following?

0 - not at all | **1** - several days | **2** - more than half the days | **3** - Nearly every day

1. Feeling nervous, anxious, or on edge
○ 0 ○ 1 ○ 2 ○ 3

2. Not being able to stop or control your worrying
○ 0 ○ 1 ○ 2 ○ 3

3. Worrying too much about different things
○ 0 ○ 1 ○ 2 ○ 3

4. Trouble relaxing
○ 0 ○ 1 ○ 2 ○ 3

5. Being so restless that it's hard to sit still
○ 0 ○ 1 ○ 2 ○ 3

6. Being easily annoyed or irritable
○ 0 ○ 1 ○ 2 ○ 3

7. Feeling afraid as if something awful might happen
○ 0 ○ 1 ○ 2 ○ 3

Total: _____

If you checked off *any* problems, how difficult 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

Custody and Legal Consent for Treatment

I am legal guardian of (Child's Name) _____ and hereby certify that I have legal custody of the child/adolescent being treated and am legally empowered to make medical decisions concerning him/her.

Custody Agreement: If the parents are divorced and the custody is "joint legal", both parents will need to sign the consent for treatment. However, if parents are divorced and only one parent signs the consent for treatment a **copy of the custody agreement** must be provided (If applicable, please send copy to **care@inlandpsych.com**). This agreement must reflect which parent obtains authority over medical decision making. If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, please note that you may be in violation of a court order if you fail to inform the other parent of your child receiving psychiatric services.

_____ _____

Name of Guardian/Parent Date

_____ _____

Name of Guardian/Parent Date

We/I have:

○ Sole Custody ○ Joint Custody

If you have joint legal custody or guardianship and do not know the location of the other parent/legal guardian, please check box

☐ Location Unknown

_____ _____

Parent/ Legal Guardian Signature Date

Name _____ Date _____

Over the last 2 weeks, how often have you been bothered by any of the following?

0 - not at all | **1** - several days | **2** - more than half the days | **3** - 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 have notices. 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

○ 0 ○ 1 ○ 2 ○ 3

Total: _____

If you checked off *any* problems, how difficult 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

Right of Access Form for Family Member/Friend

I, _____ , direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____
Contact Information:

_____

Name: _____ Relationship: _____

Contact Information:

_____

Health information to be disclosed upon the request of the person(s) named above

○ **Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR**

○ Disclose my health records as above, BUT DO NOT disclose the following (check as appropriate):

☐ Mental health records ☐ Communicable diseases (including HIV and AIDS)

☐ Other (please specify):

_____

☐ Alcohol/drug abuse treatment

Forms of Disclosure (unless another format is mutually agreed upon between my provider and designee):

○ An electronic record or access through an online portal
○ Hard copy

The authorization shall be effective until:

○ All past, present, and future periods, OR
○ Date or event: _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name: _____ Date of Birth: _____

_____ _____
Client Signature Date