Clear Form

Psychiatric Centers at San Diego, Inc. Medical Group

PATIENT REGISTRATION

TODAY'S DATE	NEW PATIENT ☐	CHANGE OF INSURANCE ☐	CHANGE OF INFORMATION ☐	**FOR OFFICE USE ONLY** **MRN:**

FIRST NAME	MIDDLE NAME	LAST NAME

MAILING ADDRESS:	CITY	STATE:	ZIP CODE:

HOME PHONE WITH AREA CODE	CELL PHONE WITH AREA CODE	WORK PHONE WITH AREA CODE

BIRTHDATE	AGE	SEX ☐ Male ☐ Female ☐ Transgender ☐ Other (specify) _____	SOCIAL SECURITY #

DRIVER'S LICENSE #	MARITAL STATUS ☐ Widowed ☐ Domestic Partnership ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Life Partner ☐ Other (specify) _____	EMPLOYER

EMPLOYER'S ADDRESS	EMPLOYER'S PHONE NUMBER WITH AREA CODE

CONFIRM APPOINTMENTS? **This is an automated confirmation system. By selecting yes, you are agreeing to a message being left on the daytime phone number provided.* ☐ YES ☐ NO	DAYTIME PHONE NUMBER TO CONFIRM APPOINTMENTS: ( )

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN'S NAME	PHYSICIAN'S PHONE NUMBER WITH AREA CODE

PRIMARY CARE PHYSICIAN'S ADDRESS

MAY WE SEND A COORDINATION OF CARE LETTER TO YOUR PCP SUMMARIZING YOUR VISIT? ☐ YES ☐ NO

REFERRED BY, IF OTHER THAN YOUR PRIMARY CARE PHYSICIAN:

PHARMACY INFORMATION

Please bring a list of all current medications you are taking to your next visit.

PHARMACY NAME AND ADDRESS	PHARMACY PHONE NUMBER WITH AREA CODE	PHARMACY FAX NUMBER WITH AREA CODE

If you have a prescription through a local pharmacy and need a refill, please notify the pharmacy so they can fax/electronically send the request to our office for approval, and allow 72 hours for processing. Even if your prescription label indicates zero refills, you still need to contact your pharmacy so they can fax your requests to us. This will greatly speed up the process for both you and our office. Please do not call our office for refills, as you will be directed to contact your pharmacy. If for some reason you require a written prescription, please allow one week for processing.

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT
HOME PHONE WITH AREA CODE	WORK PHONE WITH AREA CODE	CELL PHONE WITH AREA CODE

FOR OFFICE USE ONLY

Date Completed _____/_____/_____ Employee: _____Clinician: _____MRN: _____

Psychiatric Centers at San Diego, Inc. Medical Group

PATIENT REGISTRATION

RESPONSIBLE PARTY INFORMATION

(Must Be Completed By Person Signing Form)

FIRST NAME	MIDDLE NAME	LAST NAME
BILLING ADDRESS: STREET NO. & NAME CITY	STATE	ZIP CODE
HOME PHONE WITH AREA CODE	CELL PHONE WITH AREA CODE	WORK PHONE WITH AREA CODE
RELATIONSHIP TO PATIENT ☐ Spouse ☐ Parent ☐ Other (specify) _____	SOCIAL SECURITY #	DRIVER LICENSE #

INSURANCE INFORMATION

(Please Provide Copies of ALL I.D. Cards – FRONT and BACK, if Applicable)

☐ **Please check here if you have no insurance and you will be solely responsible for payment (skip to the next page).**

PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
INSURANCE PHONE NUMBER WITH AREA CODE	EFFECTIVE DATE	INSURANCE PHONE NUMBER WITH AREA CODE	EFFECTIVE DATE
CLAIM ADDRESS STREET NO. & NAME CITY STATE ZIP CODE		CLAIM ADDRESS STREET NO. & NAME CITY STATE ZIP CODE	
SUBSCRIBER'S NAME	DATE OF BIRTH	SUBSCRIBER'S NAME	DATE OF BIRTH
SUBSCRIBER'S ID#	SUBSCRIBER'S SSN #	SUBSCRIBER'S ID#	SUBSCRIBER'S SSN #
RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify) _____	EAP BENEFITS ☐ YES ☐ NO	RELATIONSHIP TO SUBSCRIBER ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify) _____	EAP BENEFITS ☐ YES ☐ NO
IS YOUR CONDITION WORK RELATED? ☐ YES, Date Of Injury: _____ ☐ NO		INDICATE PERSON TO DISCUSS BILLING ISSUES WITH: ☐ SUBSCRIBER ☐ OTHER (specify): _____	

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ AND AGREE TO THE CONDITIONS SET FORTH. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT, UPON REQUEST, AT THE TIME YOU SIGN.

The undersigned understands that verification of insurance benefits on any policy(s) is completed as a courtesy by PCSD and PCSD shall be held harmless should the account be rejected by the insurance carrier(s) in whole, or in part. It is the undersigned's responsibility to understand and confirm insurance policy limitations and/or exclusions directly with the policy holder.

The undersigned certified that he/she has read the foregoing, and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accepts the terms, and does hereby assume responsibility for the payment of all charges for such services.

I hereby authorize Psychiatric Centers at San Diego, Inc. Medical Group to release all information; including psychiatric, psychotherapy notes, drug and/or alcohol, concerning my case to my primary care physician and the person or entity who referred me for evaluation, other healthcare entities (laboratories, hospitals, etc.), and to my insurance company or other third party payor, funding sources or their agent for payment or review. This consent may be revoked unless it has already been relied on and if not earlier revoked shall terminate when disclosure is no longer reasonably necessary to effect the purposes outlined above. Information will not be released to any other source without the patient's prior approval. **I/WE AGREE TO THE CONDITIONS AS SET FORTH ABOVE.**

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes direct payment to PCSD of any insurance benefits otherwise payable to or on behalf of the undersigned for this service, at a rate not to exceed PCSD's regular charges. Furthermore, I hereby assign any and all sums of money payable to me under the terms of any insurance policy, contract or other third party entitlement on account of the services rendered by PCSD. It is agreed that payment to PCSD, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. It is also understood that this authorizes PCSD to retain my signature on file for all insurance claims submitted for subsequent admissions, in compliance with the signature on file provisions of third party carriers. This assignment is irrevocable.

Patient Name: _____

Financial Responsible Party:_____ (Print)

Financial Responsible Party:_____ (Signature)

If unable to send with signature, please type your full name as your signature.

Witness:_____

Date:_____

Psychiatric Centers at San Diego, Inc. Medical Group

PATIENT REGISTRATION

CONDITIONS OF TREATMENT AND FINANCIAL ACKNOWLEDGEMENT AGREEMENT

Patient Name: _____

_____(Initial) I hereby consent to a mental health evaluation so that the attending mental health provider can use clinical judgment that is necessary and advisable for the diagnosis and/or treatment of the named patient at Psychiatric Centers at San Diego, Incorporated Medical Group (PCSD). I hereby certify that the information on this form is correct to the best of my knowledge and in consideration for the named patient.

_____ (Initial) I understand, if for any reason an appointment must be canceled by the patient, 24 hours notification will be given to the clinician's office. Failure to properly notify PCSD will result in a charge for the time reserved. The office, not the answering service, must be notified of the cancellation. If you are unable to cancel your appointment at least 24 hours in advance or no show for your scheduled time, you will charged as follows:

- $60 for an appointment with a Psychiatrist (M.D., D.O.) or Nurse Practitioner (NP)
- $70 with Psychologist/Assistant (Ph.D., Psy.D.)
- $60 with a Master level therapist (LCSW, MFT, LPCC)
- $30 for group therapy appointment (this includes group appointments for ABA)
- $30 for any ABA (Applied Behavioral Analysis) services

_____ (Initial) I understand, if for any reason an appointment for Psych Testing, ADD/ADHD Testing, Neuropsychological Testing or any other type of Mental Health Testing must be canceled by the patient, 48 hours notification will be given to the clinician's office. Failure to properly notify PCSD will result in a charge for the time reserved. If I am unable to cancel my appointment at least **48 hours in advance** or no show for the scheduled time, I will be charged **$70 *per hour* reserved for the testing services.**

_____ (Initial) I understand that if for any reason my clinician is asked to complete a form on my behalf, I will be responsible for a reasonable and customary charge.

_____ (Initial) I understand that according to government insurance programs, PPOs (Preferred Provider Organizations), and HMOs (Health Maintenance Organizations), any plan co-pays or share-of-cost must be paid at the time of service. Failure to do so WILL result in a $15.00 service charge, and MAY result in postponement or cancellation of future visits.

_____ (Initial) I further agree that, other than the above-referenced insurance programs, I will pay all charges that apply to me and members of my family shown by statements, promptly upon presentation thereof, unless credit arrangements are agreed upon in advance in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. I understand that if the clinician is subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional services to me, I will be responsible for paying for all time expended on preparation, report writing, and/or other documents required. There is a fee of $25 on all returned checks. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper to any collection agency and/or its designee. I consent to PCSD releasing my name and account balance and further information as required for the satisfaction of my account.

_____ (Initial) It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof.

Quality Assurance: PCSD has an active Quality Management and Improvement Program. If you feel that the care you were rendered, or the services you received from PCSD's staff and/or clinicians was unsatisfactory, we encourage you to report this to your clinician or to the office secretary. You may also call Quality Assurance at (619) 528-4600 extension 6414.

A copy of this agreement is as valid as the original.

As a PCSD Patient

You have the right to receive services:

- From qualified, competent Health Professionals who are focused on your care, and reasonably accessible.
- In a physical environment that is safe, sanitary, and conducive to effective treatment, and which appropriately safeguards your rights to privacy and confidentiality.
- With respect and dignity for cultural and ethnic identity, religion, disability gender, age, marital status and sexual orientation.
- That emphasizes your participation in developing a treatment plan which is specific to your needs, and includes your agreement and responsibility to work toward defined goals.
- Free of unprofessional involvement with providers or staff.
- And the responsibility to participate with practitioners in decision making regarding your treatment.

You have the right to obtain current information concerning:

- Names and credentials of Health Professionals involved with your care, and to receive information about the organization, its services, its practitioners and providers, and patient's rights and responsibilities.
- Diagnosis, recommended treatment and potential alternatives, accompanying risks, benefits and costs in terms that you can reasonably understand.
- Services available and related charges, including charges for services not covered under your health benefit plan.
- Circumstances or conditions under which your care may be transferred to another Health Professional, treatment program or facility, and the accompanying risks, benefits, and costs of such a transfer.
- Practices that relate to your care and treatment services.
- Your responsibilities to ensure better treatment outcomes.
- Records pertaining to your care, having the information explained or interpreted as necessary, except when protected or restricted by law. An adult has the right to review his/her record and to provide written addendum as provided for under the California Health and Safety Code.
- Resources available through PCSD for communicating concerns or questions and for resolving disputes, conflicts or grievances.
- Advance Directives in compliance with the Patient Self-Determination Act (Section 4751), as amended, and other appropriate laws.

  Advance Directive: Yes:☐ No:☐ If yes, you may ask the front office staff for additional information.

You have the right to be treated with respect and recognition of your dignity and right to privacy and confidentiality:

- In case discussions, consultations, examinations, and treatment services.
- In communications and records pertaining to care, except in cases such as suspected abuse and danger to self or others, when reporting is permitted by law.
- Due to confidentiality, no cameras, pictures, audio, video recording, social media, disclosure of any confidential information or group therapy content, and disclosure of who's attending group or receiving services are allowed. Violation of confidentiality could result in administrative discharge from care.

- In cases where clinical information is important to share to assure medical appropriateness, such as to a referring primary care physician. A signed release will be obtained before sharing any information and the confidentiality of the information will be emphasized when it is released.

  Records of patients treated for abuse of alcohol and/or drugs are afforded special protection under Federal laws and regulations (42 CFR, Part 2). Generally, neither your provider nor our staff may say to a person outside PCSD that you may be receiving treatment for alcohol and/or drug abuse, nor may he/she disclose any information identifying you as an alcohol or drug abuser **unless 1)** you consent in writing; **or 2)** the disclosure is allowed by a court order; **or 3)** the disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation; **or 4)** you commit or threaten to commit a crime either at PCSD or against any person who works for PCSD.

  Violation of the Federal law and regulation by PCSD, its providers and/or employees is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

You have the right/responsibility:

- To provide us with the information needed in order to care for you.
- To a candid discussion of appropriate clinical treatment options for your condition, regardless of cost or benefit coverage.
- To be honest about facts, feelings or ideas that relate to your care and to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- To follow plans and instructions for care as agreed upon between you and your practitioners.
- To attempt to understand the clinical problems identified, follow the directions and advice offered by your practitioner and ask for clarification if you do not understand issues that relate to your care and to develop mutually agreed-upon treatment goals, to the degree possible.
- To keep appointments and cooperate with the providers and staff.
- To be considerate, respectful and supportive of the rights of other patients, providers, and staff.
- To safeguard the confidentiality and privacy of your own personal care as well as that of other patients.
- To communicate concerns, complaints or grievances through appropriate channels.
- To voice complaints or appeals about the organization or the care it provides.
- To make recommendations regarding the organization's patient's rights and responsibilities policies.

My signature below confirms that I have received a copy of this document detailing my right and responsibilities as a PCSD Patient and that I also have received a copy of PCSD's Notice of Privacy Practices Policy.

_____

Patient Signature Date

**If unable to send with signature, please type your full name as your signature.*

CONSENT TO PARTICIPATE IN TELEHEALTH

Patient Name: _____ MRN: _____

1) I hereby consent to engaging in Telehealth with Psychiatric Centers at San Diego Medical Group, Inc. I understand that Telehealth includes the practice of health care delivery, diagnoses, consultation, treatment, and education through the use of interactive audio, video, or other electronic data communication for my treatment (i.e. mental health, substance abuse, psychotherapy, etc.).

2) The benefits of Telehealth include having access to medical specialists and additional medical information and education without having to travel outside of my local health care community. A potential risk of Telehealth may occur due to technical problems, and/or my specific medical condition. A face-to-face consultation still may be necessary after the Telehealth appointment.

3) In addition, I understand that Telehealth treatment is different from in-person services and that my provider has the right to refer me to a different form of treatment that requires in-person services. If needed, I will be referred to a provider in my geographic area that can provide such services. I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

4) All laws concerning patient access to medical records and copies of medical records apply to Telehealth. All existing confidentiality protections under federal and California law apply to information used or disclosed during your Telehealth consultation. As such, I understand that the information disclosed by me during the course of my services is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

5) I understand that I may withhold or withdraw my consent to Telehealth services at any time before and/or during the consult without affecting my right to future care or treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

6) I consent to allowing the use of my email address. I am aware that email communications received may include the use of the name of the provider I am seeing and/or the business name.

7) I am aware that in the case of an emergency, I will contact 911. If my request is urgent in nature, I will contact my provider's office for assistance. I understand the use of the Telehealth program is for routine messages only.

I have read and agree to receiving services via Telehealth and I understand the information provided above.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Relationship of Representative to Patient

If unable to send with signature, please type your full name as your signature.

PCSD

PSYCHIATRIC CENTERS AT SAN DIEGO

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov.

Osteopathic physicians and surgeons (D.O.) are licensed and regulated by the Osteopathic Medical Board of California. (916)928-8390 www.ombc.ca.gov.

The Department of Consumer Affairs' Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints you may contact the Board on the Internet at www.psychology.ca.gov, by e-mailing bopmail@dca.ca.gov, calling 1-866-503-3221 or writing to the following address: Board of Psychology 1625 North Market Blvd, Suite N-215, Sacramento, CA 95834.

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov or by calling (916) 574-7830.

Christopher Morache, M.D., President
P.O. Box 609001 • San Diego, California • 92160
Phone (619) 528-4600 • Fax (619) 528-4625
www.PsychiatricCenters.com