East Bay Psychopharmacology Group
3860 Blackhawk Road, Suite 120, Danville, CA 94506
(925) 264-4069, Fax (925) 277-1116
www.EastBayPharm.com, email: ebpgoffice@comcast.net
J. Kirk Hartman, M.D. Said A. Ibrahimi, M.D. Ameek Mundi, D.O.

You have an appointment with one of our doctors.

If you need to cancel this appointment, please give us 3-day notice. Canceling with less notice will subject you to an appointment change fee of $75. This must be paid before a change in this appointment can be made. We schedule 60 minutes for this appointment and last minute cancellation keeps us from serving others who are waiting to see your doctor.

We kindly ask that you do not cancel this appointment without appropriate notice.

It is very important that you fill out and bring these forms with you. There is a fair amount of information needed and it may take a while to fill out all this information. If you have any other information about past evaluations, please bring a copy for the doctor.

The charge for the initial evaluation is $510. This includes an office charge of $50 which is not billable to your insurance. A credit card on file is required for all new patients.

Please be sure that the physician you are seeing is a provider for your insurance. We do not guarantee coverage if your insurance considers the physician out of network. A credit card is required to guarantee payment and will be needed on your first visit. We are unable to see you without a credit card on file. We also charge an administrative fee of $50 once per year.

Thank you.

Your Doctors at EBPG

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Dear Patient,

Please fill out the intake packet and bring it with you on the date of your appointment. Please also bring copies of all past testing, psychiatric or psychological treatment records, school/college records and psychiatric inpatient records/discharge summaries, if applicable.

About the evaluation

There are no standard psychological or laboratory tests by which one can make a psychiatric diagnosis. The diagnosis is made by listening to the presenting concerns, going over the records, reviewing the family and patient's history, conducting interviews with the patient, the family, and others, if necessary.

The initial evaluation will help you determine

What may be the underlying reason for the problems? Are there any psychological, medical, neurological, or genetic problems underlying the condition? Do the problems present a psychiatric disorder or a variant of normal behavior? What can be done to address the problems and what will happen if we do nothing?

The initial evaluation takes approximately one hour, sometimes longer and consists of:

1. Patient and family interview
2. Discussion of findings and presentation of diagnostic impression
3. Treatment recommendations

The evaluation will give you a good understanding of what's going on. There are many ways to deal with the problems. Many patients and the families are uncomfortable about psychiatric medications. We want you to know that medications are not always recommended and often are not even appropriate. The decision about the medication depends on the nature and severity of the problems, the patient's age, associated issues, but ultimately, on the best available treatment option.

If a medication is prescribed, you will be scheduled for follow-up appointments in one week to one month in time, depending on the problems and the prescribed medication(s).

We look forward to seeing you and hope that we can be of service.

Your doctors at EBPG

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Patient Data – Adult

Date_____

Patients First Name_____**Last Name**_____

Date of Birth _____ **Male**_____ **Female**____

Patient's Social Security Number _____

Address _____

City_____**State, Zip** _____

Employed By_____

Main Phone_____**2nd phone** _____

Email (1)_____

Email (2) _____

Which phone number would you like to receive call or text reminders _____

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Financial Responsibility Form

(Required, please fill completely)

Date_____

Patient's Name (please print) _____

Responsible Person's Name, if not patient _____

Address _____

City_____State, Zip _____

Phone_____Cell _____

Employer Name _____

Employer Address _____

_____

Work Phone Number_____Social Security Number _____

Date of Birth_____

The office will keep a current credit card on file. I allow the office to charge fees not coverable by the insurance such as for non-coverage, yearly admin charge, unmet deductibles, unpaid copays, and no-show charges. A statement of such charges will be sent to you.

I agree to pay all bills as presented and all reasonable fees associated at the time with the collection of such charges including fees for bounced checks, rush Rx, yearly admin charges, copays, phone consultation charges not covered by insurance, same day cancellation and no-show fees, request for copy of records, school form filling etc. per schedule of fees attached currently in force.

Signature_____ Date _____

Relationship to patient (if other than patient_____

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Consent to Release and Exchange Information

If you have seen other professionals regarding this problem and would like us to co-ordinate with them, please provide us this consent. For young patients, his or her pediatrician must be added.

Patients First Name________________________**Last Name**____________________________

Is Patient over 18 years old? ______________

If no, Guardian's Name ____

I am requesting you to provide all pertinent medical information about the patient listed above to doctors of East Bay Psychopharmacology Group. This information may be in electronic from such as a PDF file sent via email (ebpgoffice@comcast.net) or by hard copy mailed to above address.

I am giving my consent to both parties to share and exchange information as appropriate for the care of the patient.

Professional / Specialty / Family ____

Business Name____

Address___________________________________**City**________________________________

State, Zip______________________**Phone**___________________**Email**___________________

Professional / Specialty / Family ____

Business Name____

Address___________________________________**City**________________________________

State, Zip______________________**Phone**___________________**Email**___________________

Professional / Specialty / Family ____

Business Name____

Address___________________________________**City**________________________________

State, Zip______________________**Phone**___________________**Email**___________________

Signature of Patient (if over 18 years of age) ____

Signature of Guardian_________________________________**Date** ______________________

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Office Policies and HIPAA Policy Acknowledgement

- Our HIPAA policy is posted on our website: www.EastBayPharm.com. Please be sure to read it.
- The office staff is available to answer your call from 10 AM to 4 PM. Monday to Thursdays and we are available by email.
- A $50 admin fee is charged yearly for all accounts. This fee is not billable to insurance and needs to be paid annually.
- We charge $175 for all changes and cancellation of appointments with less than 2 business-day notice. There are no exceptions for this (including sickness, work travel, etc.) This is a typical policy for psychiatric office where a considerable time is set aside with no double booking.
- We use an electronic reminder service for your upcoming appointment. The reminders will come via email and phone.
- You may email us about yourself or the patient if you wish. Please clearly indicate the patient name and the doctor to whom your communication is directed. The doctors review the emails daily in most cases. If it is urgent, please call the office instead of emailing. Standard emails are not hack-proof but are considered HIPAA compliant.
- Refills are done using electronics means. This is secure and avoids errors. **Please do not call the office for refills.**
- Most Rx refills require regular follow-up as suggested by the doctor. Rx refill requests must be made in writing via website or email.
- For medication refills (Schedule II medications) we require a 7 day notice. Other medications require a 3 day notice. Urgent refill requests, with less than 3-day notice will be charged a $10 rush fee.

Patient (please sign): _____

If you will be using your medical insurance to pay for visits to this office….

- Insurance coverage is for a particular doctor - not the office.
- If your insurance changes, let us know immediately. Transactions older than 90 days cannot be billed to insurance.
- If you have any other insurance plan, please send the superbill given to you by the office to your company. They will reimburse you directly based on your deductible and out of network coverage.
- We require a credit card on file for timely payment of amount due to this office for all unpaid charges.
- We do not verify your coverage. This is your responsibility.
- If you are seen by the doctors and your insurance deems the charges not covered, you are responsible for them.
- Please check with your insurance as to what your deductible is. During the first quarter of the year, you are expected to pay the contracted rate at the time of service. We require full payment of agreed upon rate at time of visit if you have not met your deductible.
- Phone consultations over 10 minutes are charged. Your insurance most likely will not cover these.
- Some services such as phone consultations with other providers, review of records, no-show charges, cancellation fees, form filling, reports etc. are often NOT a reimbursable expense. If these services are used or requested by you, you are responsible for their charge.
- If after billing your insurance company we find that you do not have coverage, have not met the deductible, or for any other reason, the amount due will be charged to your credit card on file after 30 days.
- Please call your insurance and make certain that you are covered for seeing this office, the doctor with whom you have the appointment and understand clearly your deductibles and your coverage. For purposes of meeting your deductible, please be advised that typical charges from this office may be app. $1500 per year.

Insured's Signature _____

Please read carefully and sign. This is a required form if you want us to bill your insurance.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

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

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.
(2-08)

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Contract for Controlled Substances

Controlled substance medications (i.e., benzodiazepines and stimulants) are very useful. However, they have potential for misuse and therefore are controlled by local, state, and federal authorities. Because my provider is prescribing such medications for me, I agree to the following conditions:

1) I am responsible for the controlled substance medications prescribed to me. If my prescriptions and/or medication are misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced regardless of the circumstances.

2) I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from EBPG. Besides being illegal to do so, it may endanger my health. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves the concomitant use of non-prescription or illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

3) I am aware that all requests for prescriptions must be in writing during business hours.
    a. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. Renewals are based upon keeping scheduled appointments.
    b. Refills will not be made as an "emergency". No controlled medications can be ordered when the office is closed. I understand the importance of following my treatment plan as directed by my physician and agree to keep my scheduled appointments.

4) I understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as: failure in taking medications as prescribed, utilizing other illicit drugs, obtaining similar medications from others, or abuse of controlled medications, I may be subject to dismissal from this practice.

5) I understand that the main treatment goal is to improve my ability to function. I am being given potent medication to help me reach that goal and agree to help myself by following better health habits. I understand that using illicit drugs will negatively impact my progress. Continued use of illegal or illicit substances after warning can be cause for termination of medical care and reporting to authorities.

I have read this contract and fully understand its content and the consequences of violating this contract. By signing below, I accept the above treatment agreement.

Patient or Guardian Signature:_____ Date: _____

Dear Patients,

This letter is to inform you of our updated billing practice in regards to receiving patient payments. Effective January 2015, we now require a credit or debit card to be on file with our office or full patient payment of services at each appointment.

Why the change? There are several reasons for this change. With the changing environment in healthcare, in particular the Affordable Care Act and High Deductible Health Plans (HDHPs) more responsibility of payment is being placed on the patient. We need to be sure that patient balances are paid in a timely manner. To do this, we need to ensure we have a guarantee of payment on file in our office.

What is a Deductible and How Does It Affect Me? An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay. For example, if your policy has a $2,000 deductible, you must pay the first $2,000 of medical expenses before the insurance company begins to pay for any services. This works just like the deductible for your car insurance or homeowner's insurance policy does.

When do I have to pay for services? Any time you receive medical care, you will be expected to pay in full for your services until your deductible is met. If you have a very large deductible, called a high-deductible insurance plan, you may have to pay out of pocket for most of your primary care services.

How will I know when my deductible has been met? You can call your insurance company at any time to check on how much of your deductible has been met and some insurance companies have this information available online. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay if the amount went to your deductible when they send you an Explanation of Benefits (EOB.)

How will I know how much you are going to charge me? You will receive a letter in the mail (or e-mail) from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB.) This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay.

Then what? We receive the same Explanation of Benefits (EOB) that you do. Most Insurances will send your EOB prior to us receiving our copy. It arrives about 10-20 days after your appointment has been billed. We look at each EOB carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a statement for in the mail.

All patients with commercial insurance are required to keep a credit or debit card on file. If you do not wish to keep a card on file, we will expect an estimated payment at the time of service. For example, if your commercial insurance requires $175.00 to be paid for standard service and your deductible is not met, you will be expected to pay the $175.00 via check or credit card before you are seen, but this will not include ancillary charges that may arise out of your visit. Once we receive the EOB on your visit we will send a statement if your patient responsibility is higher than the originally collected amount or you will have a credit on your account if your patient responsibility is lower than the originally collected amount.

Once we receive the insurance EOB for your visit we will charge the credit card on file the exact amount as per the EOB that is stated to be patient responsibility. Once charged, we will email you a receipt of payment.

The other items that can be charged are no-show charges, and unpaid copays.

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Credit Card Payment Authorization

In order to coordinate coverage of services for patients, we require patients to provide us with a valid credit card which we will charge following office visits for amounts owed for co-payments, deductibles, and co-insurance by patients for services rendered by your physician. In the event a patient misses or cancels an appointment without two business days' notice, EBPG will charge the appropriate fee pursuant to our cancellation policy to the cardholder's credit card. EBPG will not charge the cardholder's credit card more than $460.00 in a single transaction.

I_____[name of cardholder] hereby authorize EBPG to keep my credit card information provided below on file and charge my credit card following office visits, from the first date of service, for any amounts owed for services rendered to_____[name of patient if cardholder is parent/guardian]/me which are not covered by insurance, including co-pays, deductibles, and co-insurance. In addition, I authorize EBPG to charge my credit card fees for missed or cancelled appointments by the patient/me. I understand that I may elect receive receipts via mail or email for any amounts charged to my credit card by EBPG for services rendered to the patient/me. I further understand that such amounts charged to my credit card will appear on my credit card statement.

I understand that this authorization is valid for one (1) year from the date written below unless I cancel this authorization by providing written notice to EBPG.

Patient:_____Cardholder Name: _____

_____

Cardholder Billing Address City State Zip

Email:_____
To receive receipts after card has been charged

_____ _____ _____

Digits of Credit Card Expiration Date Security Code

_____VISA _____MasterCard

Cardholder/ Account Holder Signature:_____Date:_____

Medicare Opt Out Agreement

This form is to be completed by all patients, regardless of age

Dear patient,

As a non-medicare provider, we are obligated to ask you to sign this agreement.

Patient_____
and
Doctor _____

- If the patient is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on Jan 1, 2013 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.
- Physician agrees to provide the following medical services to Patient (the "Services"): Psychiatric evaluation and management
- In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:
- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

Patient Signature_____

Date_____

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Schedule of Fees

(As of Dec 2015- Subject to change)

Fee	Charge	Notes
New Eval. appointments	$460	Approx. 1 hr
Yearly admin charge	$50	Payable first visit of the year- not covered by insurance. This is in addition to your copay.
Regular follow-ups	$175	App. 15 to 30 min.
Longer follow up appts	$305	App. 30 to 40 mins or *complex*
Failed or cancelled appointment charge	$75-$175	All changes and cancellations less than 48 hour notice
Rush RX refill	$10	48 Hrs or less to fill Rx
Copy of Records	$30	See website for more details
Letters/Forms	$50 - 150	Personal letters/forms for schools, lawyers, psychologists, airlines, others
Phone Consultations	$175	With patient or others on patient's behalf. These may not be covered by your insurance.

Patient Signature: _____

Date: _____

ADULT PERSONAL INFORMATION

(*To be completed by patient or caretaker prior to first appointment*)

Name:	last	first	middle initial
Date of Birth:		Age:	• Male • Female
Current Address	_____ City:_____State:_____Zip: _____		
Home Phone #		Is it OK to leave a message? Yes No	
Work Phone #		Is it OK to leave a message? Yes No	
Cell Phone #		Is it OK to leave a message? Yes No	
Email address(es):			
Occupation			
Employer/ School			
Marital Status			
Emergency Contact		Phone:	
Contact information of a person completing this form if not a patient			
Name		Ph:	
Address		Email:	
Relationship to a patient			

List the reason(s) for seeking help at this time (when started):

a)_____( )

b)_____( )

c)_____( )

d)_____( )

Have you seen other specialists for <u>these</u> problems/symptoms? (appr. dates)

_____( )

_____( )

_____( )

Your Primary Care Physician:

*Name*_____Phone: _____

Address _____

Other Physicians and Therapists currently involved in your care

*Name*_____specialty_____Phone_____

Address _____

Reason _____

*Name*_____specialty_____Phone_____

Address _____

Reason _____

MEDICAL HISTORY

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Not so good ☐ Very bad

Do you have serious or chronic medical conditions, accidents or injuries, including head injuries? Yes No

Please *describe* _____

_____

_____

_____

_____

_____

Medications: Please list all current medications, including vitamins and supplements

Name of the medication	Daily Dose	Prescribed by
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you had allergic reaction to any medication? Yes No

What medications and extent of reaction

_____

_____

Recently, did you have

unexplained weight loss or gain? (circle if yes) _____

big change in appetite, increase or decrease (circle)_____

big change in sleep pattern (briefly describe)_____

big change in alertness and energy during the day (briefly explain)_____

History of medical and psychiatric hospitalizations

Age/ Year	Reason for Hospitalization / Surgery	Treatment

MEDICAL HISTORY:

Please check all that applies

✓	**Disorders (circle)**	**Comments, diagnoses, description**
	Heart diseases (heart attack, arrhythmias, weak heart)	
	Blood Pressure problems History of stroke?	What's your BP? /
	Blood vessels disorders varicose veins, blocked or inflamed arteries, thrombosis	
	High cholesterol or lipids	
	Snoring or Sleep Apnea	
	Hearing loss	Do you wear hearing aid? Yes No
	Vision loss, eye disease, cataract, glaucoma, macular degeneration, etc.	Do you wear glasses? Yes No
	Chronic muscle, joint problems, pain	
	Skin, hair, or nails problems, rush, sores that don't heal	
	Shortness of breath	
	Lung Dis. (e.g. emphysema, asthma, chronic cough, COPD)	
	Difficulties swallowing	
	Bloating and heartburns	
	Elimination problems, chronic constipation, diarrhea	
	Other GI problems, IBS, Crohn's, etc.	
✓	**Disorders (circle)**	**Comments, diagnoses, description**
	Diabetes, Thyroid, other endocrine problems	

	Blood disorder (anemia, abnormal bleeding, etc.)	
	Enlarged lymph nodes	
	Autoimmune disorders (e.g. lupus)	
	Dizziness and lightheadedness	
	Headaches chronic or constant	
	Multiple sclerosis, Parkinson's	
	Tremors, muscle spasms, numbness, history of seizures	
	Stroke, head trauma	
	Muscle weakness (local or general)	
	Difficult, frequent, or painful urination	
male	Erectile dysfunction	
	Prostate trouble	
female	Last menstrual period	(date)
	Sexual problems: pain, discomfort, etc.	

Are you right or left handed? Right Left

Additional Medical Information

_____

_____

_____

_____

Health Habits

Alcohol and Other Drug use:

Do you drink, smoke, or use other (non prescribed and non OTC) drugs? **If Yes**, please answer the following questions.

Check (✓**)** all the drugs that you are using now (**Y** or **N**) / have used in the past (**YP**)

Alcohol		Nicotine (type and pack/day)	
Amphetamines		Opioids/Heroin /Painkillers	
Caffeine		Ecstasy	
Cannabis (Marijuana)		PCP	
Cocaine/Crack		Sedatives/barbiturates	
Hallucinogens/LSD		Other (please specify)	

	Alcohol	**Other Drugs**
What are your drink(s)/drug of choice?		
How much do you drink or use per day/week?		
Do you feel you have problems with alcohol or drugs?		
Has your drinking and/or drug use ever caused problems in the family, work, or in in your relationship(s)?		
Have you ever had a DUI or other drug related problems?		
Previous treatment programs (dates and locations if possible)		

	Age	living with you?	If deceased, **age** and the **cause** of death	Occupation
Spouse/partner				
Children (biological)				
Mother (biological)				
Father (biological)				
Biological G-parents				
Siblings				

FAMILY MEDICAL HISTORY

Please let us know if any of the biological family members had any of the following conditions.
If yes, please specify family member's relationship to you.

(circle)	*Relationship*	*(circle)*	*relationship*
Cancer		Anxiety/ Panic Attacks	
Diabetes, Obesity		Alcohol/Drug Abuse	
Heart disease/ heart attack High Blood Pressure		Bipolar Disorder and Depression	
Stroke		Schizophrenia	
Kidney Disease		OCD	
		Learning Disability	
Alzheimer's Disease		Mental Retardation	
Multiple Sclerosis		ADHD	
Dementia/Memory Loss		Psychiatric Hospitalization	
Seizures/Epilepsy		Suicide/ Suicide Attempts	

Other medical or psychiatric problems in members of the family

disorder	*relationship*

VOCATIONAL HISTORY

Current occupation and how long have you worked in this field? (If retired, year of retirement)	
Previous jobs:	

EDUCATIONAL HISTORY

What is the highest degree you have obtained? _____

Please list the last school(s) you have attended:

School	Year of graduation Degree/ Certificate	Check if you had special accommodations

Have you ever been diagnosed with any learning disability? Yes No

If yes, please describe_____

LEGAL HISTORY: (use additional space if needed)

Have you ever had any legal difficulties/problems or previous imprisonment? Yes No

If yes, please describe_____

Is this evaluation part of the worker's compensation proceedings? Yes No

If yes, please describe_____

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ADULT RATING SCALE

Name_____DOB_____Age _____
first *last*

Major concerns (*check all that apply):*

- ☐ Attention
- ☐ Relationships
- ☐ Professional
- ☐ Health
- ☐ Memory and thinking
- ☐ Other (please specify) _____

Please rate these behaviors: **0 – Never (None) 1 – Sometimes (Mild) 2 – Often/Always (Severe)**
(circle the most appropriate number)

Block I

0 1 2 Can't start a task
0 1 2 Hard to stay focused, easily distracted
0 1 2 Poor attention to details, careless mistakes
0 1 2 Forgetful, losing things
0 1 2 Poor planning, procrastination
0 1 2 Daydreaming
0 1 2 Leaving work unfinished

0 1 2 Impulsive decisions
0 1 2 Interrupting conversations
0 1 2 Acting before thinking

0 1 2 Fidgeting, shaking legs
0 1 2 Talking excessively
0 1 2 Moving constantly, changing positions
0 1 2 Hard to stay seated

0 1 2 Liking sameness, routine
0 1 2 Rigid and stubborn
0 1 2 Transitions are difficult
0 1 2 Perfectionist, works slow
0 1 2 Concerns about order and neatness

Block II

0 1 2 Gets into heated arguments
0 1 2 Losing temper, getting angry
0 1 2 Feelings are hurt, gets easily frustrated
0 1 2 Going through uncontrollable rages

0 1 2 Conflicts with authorities
0 1 2 Problems with the law
0 1 2 Arrests, DUI (details in few words)

_____
_____

0 1 2 Smoking cigarettes
0 1 2 Excessive drinking
0 1 2 Other drugs (legal and illegal), details

_____
_____

Block III

0 1 2 Nervous habits or tics (describe)

0 1 2 Obsessive, intrusive thoughts or images
0 1 2 Compulsive behaviors
0 1 2 Storing things, not able to discard them
0 1 2 Excessive superstitions

Block IV

0 1 2 Worrying excessively about everything
0 1 2 Feeling tense, keyed up
0 1 2 Unable to stop worrying

0 1 2 Self-conscious , feelings easily hurt
0 1 2 Easily embarrassed, sensitive to criticism

0 1 2 Panic attacks now or in the past (circle)

0 1 2 Excessive fears (crowd, heights, etc.)
0 1 2 Nervous stomach, headaches

0 1 2 Family history of anxiety, panic, and social phobia

0 1 2 Excessive tiredness and daytime sleepiness
0 1 2 Always tired, hard to stay alert

Block V

0 1 2 Unhappy most of the day, most days
0 1 2 Crying
0 1 2 Thoughts of dying
0 1 2 Feeling guilty, being too hard on self
0 1 2 Feels things will never get better
0 1 2 Not enjoying anything anymore
0 1 2 Major changes in sleep and appetite

0 1 2 Feeling worthless, inferior (e.g. I am stupid)
0 1 2 Feeling that be better off dead
0 1 2 Thoughts of suicide

0 1 2 Feeling giddy, witty and funny
0 1 2 Mood changes quickly, drastically
0 1 2 Episodes of being talkative, pressure to talk
0 1 2 Periods of extreme energy alternating with periods of excessive tiredness and calm
0 1 2 Acting recklessly
0 1 2 Thinking more about romance and sex

0 1 2 Family history of depression or bipolar disorder

Block VI

0 1 2 Feeling indifferent, not caring
0 1 2 Loosing interest in thinks that liked before
0 1 2 Feeling drained of energy
0 1 2 Not seeing friends, mostly alone
0 1 2 Sleeps too much, always tired

Block VII

0 1 2 Sleep is disturbed, interrupted
0 1 2 Hard time falling asleep
0 1 2 Sleepwalking, -talking, night terrors

Block VIII

0 1 2 Hearing what others can't hear
0 1 2 Feeling others are out to get you
0 1 2 Strange, bizarre, intrusive thoughts
0 1 2 Being suspicious

Block IX

0 1 2 Change in appetite, up or down (circle)
0 1 2 Weight loss or gain (circle)
0 1 2 Recent vision or hearing loss (circle)
0 1 2 Recent change in health (describe)

_____
_____
_____
_____

Additional Comments:

Person(s) helping with the questionnaire

_____

_____

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Message to our patients about Arbitration

The attached contract is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both healthcare providers and their courts. Arbitration agreements between patients and physicians have long been recognized and approved by the State of California. By signing this agreement, yon are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both the patients and physicians. This is because the time it takes to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of a trial and the publicity which may accompany judicial proceeding.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We are all caring doctors and do our utmost to be responsive. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.