APPLIED PSYCHOLOGICAL HEALTH, INC

PATIENT REGISTRATION FORM – PEDIATRIC

FIRST NAME________________________________ LAST NAME_______________________________ MIDDLE INITIAL_________

DOB_____________________ AGE _____________SEX____________ SOCIAL SECURITY NUMBER _______-_______-________

ADDRESS____ CITY _______________________ STATE________ ZIP____________

PRIMARY PHONE _____________________________________ SECONDARY PHONE ____________________________________

PARENTS FULL NAME ____ DOB ___________________________

ADDRESS____ CITY _______________________ STATE________ ZIP____________

PARENTS FULL NAME ____ DOB ___________________________

ADDRESS____ CITY _______________________ STATE________ ZIP____________

EMERGENCY CONTACT ______________________________ PHONE ________________RELATIONSHIP __________________

DOES A CUSTODY ARRANGEMENT EXIST FOR THIS CHILD? YES NO

If yes, the court documentation must be presented to the front desk, and appropriate consent must be obtained from all parties involved.

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
ID/Policy #:	ID/Policy #:
Group #:	Group #:
Insurance Phone #:	Insurance Phone #:
Subscriber/Sponsor Name:	Subscriber/Sponsor Name:
If Tricare, Sponsor's DOB and SSN:	**If Tricare**, Sponsor's DOB and SSN:
If Active Duty, Military Treatment Facility (MTF): Phone:	Fax:

FINANCIALLY RESPONSIBLE PARTIES, IF OTHER THAN PATIENT (GUARANTORS)

Primary Guarantor Name:	Secondary Guarantor Name:
Relationship to Patient:	Relationship to Patient:
Address (if different than above)	Address (if different than above)
Phone #:	Phone #:
E-mail:	E-mail:
DOB: SSN:	DOB: SSN:

AUTHORIZATION FOR TREATMENT

I authorize Applied Psychological Health, Inc. to provide treatment and evaluation, face-to-face or via telemedicine. I authorize the release of any medical information necessary (including the release of mental health and substance abuse, to include alcohol and drugs, and any reportable communicable diseases) to process a claim and hereby assign benefits payable to Applied Psychological Health, Inc. in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to my primary care doctor. Furthermore, any services not covered by my insurance will become my responsibility for the full payment of services rendered by Applied Psychological Health, Inc.

PATIENT/LEGAL GUARDIAN SIGNATURE ____

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PATIENT/LEGAL GUARDIAN PRINT ____ DATE______________________

PATIENT HEALTH QUESTIONNAIRE

Patient Name____ Date of Birth____________________________

Referred By____

Family Physician ____ Phone (________) _________-______________

Reason for Visit Today____

Date of Last Hospitalization________________________ Place of Last Hospitalization________________________________

Reason for Last Hospitalization ____

Medication	Dosage	Frequency	How Long

Family History	Father	Mother	Sibling	Father's Family	Mother's Family	Other
Mental Illness						
Diabetes						
Heart Problems						
Hypertension						
Alcohol/Drug Abuse						
Anxiety						
Cancer						

What are the mental health concerns you would like help with?

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PATIENT HEALTH QUESTIONNAIRE *(Continued)*

Patient Name______________________________________

Have you had or do you presently have problems with any of the following? Please elaborate:

SYMPTOMS	YES	NO	COMMENTS
Medication Allergies			
Immune deficiencies			
Anemia			
Anxiety			
Back (Spinal) Pain			
Breathing Issues			
Cancer or Tumors			
Chest Pain			
Chronic Constipation			
Chronic Cough			
Chronic Indigestion			
Chronis Sinus Infection			
Convulsions			
Corona Virus			
Depression			
Diabetes			
Dizziness			
Eye/Related Diseases			
Fainting Spells			
Frequent Colds			
Gall Bladder			
Genitals			
Hernia			
High Blood Pressure			
Inability to Focus			
Joints & Lymph Nodes			
Kidneys			
Liver Issues			
Palpitations			
Paralysis			
Pneumonia			
Poor Appetite			
Recent Weight Gain/Loss			
Skin			
Sleeplessness			
Ulcers			
Other:			

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FINANCIAL AGREEMENT

If you have medical insurance, we will file claims with your medical insurance company for the services provided by our office. To ensure the claims process is handled correctly, please ensure the information provided to our office on the patient information form is accurate and up to date. If there is a change in insurance information, please let us know immediately. We will submit to secondary insurance as long as we receive the correct information and are notified that you would like this service performed.

Deductibles, Co-Payments, and Coinsurance: Co-payments are constant and due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy, and we can only approximate the percentage covered by each plan. *Payment of the estimated deductible portion is due at the time of service.*

Authorizations: A copy of your insurance card is required at the time of the initial service. The card is descriptive and indicates whether an authorization is needed. Oftentimes, behavioral health benefits are administered by a separate company, and we must contact them to verify the necessity of an authorization. If a copy of the card is not on file as of the initial service date and the claim is denied for “no authorization,” you will be responsible for payment.

Provider Coverage: We can provide you with our list of providers that participate with your insurance company. However, we are not responsible for ensuring that our provider is covered under your particular plan provision. Each insurance company has multiple plans. The provider may participate with the insurance company, but not your particular plan. Please contact your insurance company to verify that the provider you are seeing is appropriately covered. It is ultimately your responsibility to verify your plan's coverage. *If the insurance company denies the claim for a plan provision, you will be responsible for the balance.*

Medical insurance coverage is a contract between you and your insurance company. WE ARE NOT a party to this contract. We can not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc., other than to supply factual information as necessary. *You are ultimately responsible for the timely payment of your account.*

PAYMENT METHODS AND OTHER INFORMATION: We accept cash, check, VISA, MasterCard, Discover, or AmEx Accounts can be set up on payment plans if necessary, at no additional cost.

Accounts that are more than 60 days past due will be turned over to our collection agency and reported to the Credit Bureau. Accounts that have statements returned with no forwarding address will be charged $10 and turned over to a collection agency.

All late cancellations and no-shows will be billed $100 automatically. (We require a 24-hour notice in advance to avoid charges.)
Paperwork charges do apply and can range from $50 to $200, depending on the length of the report or the number of pages to complete.

A SPECIAL NOTE: In situations of divorce, separation, court orders, child custody, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancellations).

We are committed to providing you with the best possible care, and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

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FINANCIAL AGREEMENT (cont)

I acknowledge that I have read and agree to the above Financial Policy. By signing this notice, I authorize Applied Psychological Health, Inc. to charge my credit card on file for any past-due balances. I further understand that I will be 100% responsible for all the "uncovered" services as explained.
Patient/Guarantor Signature: ____ Date: ________________________

CREDIT/DEBIT CARD INFORMATION MasterCard Visa Discover AmEx

Card Number____ Expiration ____________Security Code __________

Billing Zip Code _______________________________ Name on Card ____________________________________

Patient/Guarantor Signature: ____ Date: ________________________

PERMISSION TO RELEASE INFORMATION BY TELEPHONE

If you would like people designated by you to have information about your health, appointments, billing, and that you are a patient in this office, please complete the following information.
Any disclosure of information authorized by the patient is for the purpose of improving relationships with family and friends and of providing and maintaining a family support system.

I hereby authorize APPLIED PSYCHOLOGICAL HEALTH, INC to release information limited to my general physical health and attendance in office appointments to.

____________________________________ ______________________________ ______________________________
Name Relationship Phone

____________________________________ ______________________________ ______________________________
Name Relationship Phone

Patient/Legal Guardian Signature ____ Date ____________________

NON-DISCLOSURE OF INFORMATION

I do not wish knowledge of my condition to be released to anyone.

Patient/Legal Guardian Signature ____ Date ____________________

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APPLIED PSYCHOLOGICAL HEALTH, INC

Telehealth Treatment Consent

Information and Informed Consent for Tele-mental Health Treatment
Tele-mental health is live two-way audio and video electronic communications that allow therapists and clients to meet outside of a physical office setting.

Client Understanding:
I understand that my participation in tele-mental health services is entirely voluntary, and I retain the right to withdraw this consent at any time. I am aware that none of the tele-mental health sessions will be recorded or photographed, and I agree not to make or allow audio or video recordings of any portion of the sessions. I understand that the laws protecting privacy and the confidentiality of client information also apply to tele-mental health. No information obtained using tele-mental health that identifies me will be disclosed to other entities without my explicit consent.

I understand that tele-mental health is performed over a secure communication system highly resistant to unauthorized access. I am reassured by the security measures in place, even though I understand that any internet-based communication is not 100 % guaranteed to be secure. I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I know the potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist or I may discontinue the tele-mental sessions at any time if it is felt that the video technology is not adequate for the situation. In the event of an emergency during a tele-mental health session, I understand that my therapist may call emergency services and/ or my emergency contact. I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to tele-mental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re-contact.
I understand that a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of the scheduled appointment. I understand that a credit card or another form of payment will be established before the first session. I understand that my therapist will advise me about which tele-mental health platform to use, and she will establish a video conference session.

Client Consent
Client Name: ____ Date of Birth: __________________

☐ I hereby give my informed consent for the use of tele-mental health in my care.

PATIENT/LEGAL GUARDIAN SIGNATURE ____

PATIENT/LEGAL GUARDIAN PRINT ____ DATE_____________________

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Acknowledgment of Receipt of Notice of Privacy Practice

I hereby acknowledge that I have read a copy of this medical group's Notice of Privacy Practices. I further acknowledge that I may obtain a copy if requested.

PATIENT/LEGAL GUARDIAN PRINT ____

SIGNATURE____ DATE______________________

WITNESS____ DATE______________________

SPECIAL NOTICES FOR PATIENTS WITH MEDICARE, MEDI-CAL, AND TRICARE

Non-covered services

If you are requesting a service that is not a benefit of your health coverage plan, you will be asked to sign a notice or waiver acknowledging noncoverage of said services.

(Medicare – "ABN", Tricare – "Request for Non-Covered Services")

Active Duty Service Members

You need a referral from your primary care manager (PCM) for any care he/she doesn't provide. This includes urgent, routine, preventive, and specialty care services.

- • Your PCM works with your regional contractor for the referral and authorization.
- • Your contractor will try to refer you to a military hospital or clinic first.
- • If not available, you're referred to a network provider (in your region).

You can't get any care without seeing your PCM first. If you do, you may be responsible for paying for the care out of pocket.

Medi-Cal Members

You can access the ***Guide to Medi-Cal Mental Health Services*** booklet at:
https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/documents/GuideMediCal082113.pdf

This booklet will inform you of the mental health services available to you and how to access them. You may also get information on your rights under this program, the grievance/appeal process, and lists of doctors, clinics, and hospitals in San Diego County and their locations.

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CALIFORNIA 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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead accepting 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 related 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 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 court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

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 immunity from civil liability as judicial officers when acting in their capacity as arbitrators 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 the issues of liability and damages separately upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that 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 Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations 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, or by signature. It is the intent of this agreement to apply to all medical services rendered at any time for any condition. Article 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is effective, this agreement shall apply to all medical services rendered at any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services, then patient should initial here: ______________________________ 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 signing below, I acknowledge receipt of 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: ____ ______________________

Patient's or Patient Representative's Signature (Date)

By: ____ ______________________

Physician's or Authorized Representative's (Date)

By: ____ Print Patient's Name

____ ____

Print Name of Physician Medical Group or Association Name

A signed copy of this document is to be given to the patient. The original is to be filed in the patient's medical records.

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