Welcome to Community Psychiatry

Community Psychiatry's dedicated providers and staff are committed to ensuring that each and every patient receives the highest quality psychiatry services possible. This Patient Agreement establishes guidelines for your participation in treatment with us. Please read the entire Agreement and ask the front desk staff if you have any questions.

Initial Evaluations

Children. Initial evaluations for children involve two 45 - 60 minute sessions. The purpose of these sessions is to obtain a detailed history and perform a comprehensive examination. Your child's provider may request information from your child's other health care providers and school before making a definitive diagnosis and/or treatment recommendations.

Adults. Initial evaluations for adults involve one 45 - 60 minute session. Your provider may request information from your other health care providers before making a definitive diagnosis and/or treatment recommendations.

Follow-Up Sessions

Following the initial evaluation, your (or your child's) provider will discuss their assessment with you and make recommendations regarding medication(s) and/or psychotherapy. Your provider may request a blood test or an EKG prior to starting you on a particular medication. If your provider determines medication is appropriate for your treatment, our staff will schedule you for follow-up sessions as indicated during the initial phase of treatment. In these sessions, your provider will carefully monitor your (or your child's) response to the medication(s) prescribed and any side effects. These follow-up sessions typically last 20-30 minutes, although they may take somewhat longer in the early stages of treatment.

Regular Attendance

The relationship between a provider and his/her patient is a partnership and regular attendance at appointments is a critical part of your care. Although regularly scheduled visits with your provider may at times feel burdensome, this commitment helps ensure that you receive the highest quality care possible.

Late Arrivals

If you arrive late for a scheduled appointment and your provider determines that there is enough time remaining, they will see you for the remainder of your appointment time. That said, your provider may also request that you schedule an additional appointment with them.

No Show & Late Cancellation Policy*

We reserve your appointment time specifically for you and you alone. For this reason, Community Psychiatry charges a fee for no shows and appointments canceled with less than

two (2) business days' notice. Please also be advised that after you no show to or late cancel three (3) scheduled appointments, your provider may terminate their relationship with you for noncompliance. We also understand that your time and money are valuable. For this reason, our office staff will call or text you to remind you of scheduled appointments.

**Pursuant to California law, Medi-Cal patients are not charged any no show/late cancellation fees.*

Children and Appointments

We kindly ask that you do not bring your children to your appointments unless they are also being seen at Community Psychiatry, or are specifically requested to attend by your provider. Please note that we do not permit children in our waiting area without the supervision of a parent, guardian, or caretaker.

Same-Day Appointments

Many insurance companies do not pay for two mental health visits on the same day. If you have visits with your psychiatrist and therapist on the same day, you may have to pay out-of-pocket for one of these visits.

Emergencies and Urgent Consultations

For your benefit, a covering provider will be available each day after office hours until 9 p.m. to assist you with any urgent issues or problems you are having with medications. To reach the covering provider, please call us at (855) 427-2778 and listen for our covering provider's phone number. In the event of an emergency, please call 911 or go directly to the emergency room.

Forms and Documents

If indicated, medical forms will be completed by your provider while they meet with you in your session. Please notify your provider at the beginning of each session if you need certain forms completed.

Requests for Disability

Community Psychiatry does not accept patients seeking treatment for the sole purpose of obtaining disability benefits or patients seeking long-term disability benefits. It is possible that after evaluating you your provider may be willing to complete short-term disability paperwork on your behalf, however, your provider is not required to do so and may decline to assist with such a request. Your provider may also require you to schedule a separate follow-up appointment with them for this purpose.

Requests for Substance Use Disorder Treatment

Community Psychiatry providers generally do not provide treatment for substance use disorders, such as treatment for detoxification, acute withdrawal, or medication-assisted treatment. If you require substance use disorder treatment, please reach out to your insurance plan for assistance in finding an appropriate treatment provider or facility.

Medications

Our providers typically evaluate adults for one session and children for two sessions before determining whether medication is indicated for care. For child patients, the decision to start a medication often cannot be made during the first session and is usually deferred until the child's second session to allow the provider adequate time to obtain a full history and review any requested medical or school records.

To ensure the best response to any prescribed medications, please observe the following procedures:

- Always notify your provider of any side effects or problems with medications you are experiencing.
- Never stop or change the dose of a medication without first discussing it with your provider.
- Suddenly stopping medication can cause medical problems. For this reason, do not allow yourself to run out of medication.
- If you need a refill before your next scheduled appointment please call our office one week prior to running out of your medication.
- Keep your scheduled appointments. Although your provider will prescribe you adequate medication until your next visit, canceled or missed visits can prevent you from having sufficient amounts of medication and make it difficult for your provider to monitor your progress and any complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication.

NOTICE TO CONSUMERS

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

Nurse Practitioners are licensed and regulated by California Board of Registered Nursing (BRN)
(916) 322-3350 | https://www.rn.ca.gov/

LMFT and Social Workers are regulated by the Board of Behavioral Sciences in California
(916) 574-7830 | www.bbs.ca.gov

Psychologists are licensed and regulated by the Department of Consumer Affairs' Board of Psychology
1-866-503-3221 | bopmail@dca.ca.gov | www.psychology.ca.gov

I have read and agree to this Patient Agreement in its entirety

Patient Signature

Date

Patient Name

Patient Date of Birth

If you are signing this Patient Agreement as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

Signature

Date

Name

Consent to Treatment

I am voluntarily seeking psychiatry services, including medication management and/or psychotherapy, from Community Psychiatry for the purpose of diagnosis and treatment, and I hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that Community Psychiatry's providers include psychiatrists, psychiatric mental health nurse practitioners, psychologists, social workers, and marriage and family therapists. I understand that there are both risks and benefits to psychiatric treatment. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

I understand that if the patient is a minor under the age of 12 and I am consenting to treatment on the minor's behalf, I must indicate my authority and sign below. I also understand that if I share legal custody of the minor patient, by signing this consent form I am representing that all parties who have legal custody of the minor have been made aware of, and consent to the minor's treatment.

I understand that if I am a minor between 12 and 17 years of age, I have the right to alone consent to outpatient mental health treatment with Community Psychiatry and therefore must sign this consent form in order to be treated by Community Psychiatry. However, if I require prescription medication for my treatment, my parent or guardian is required to sign a separate Consent to Medications form consenting to such prescriptions.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I have the right to withdraw my consent to treatment at any time.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

If you are signing this Consent to Treatment as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

Signature _____ Date _____

Name _____

Acknowledgment of Financial Responsibility

I hereby assign payment of my insurance benefits to Community Psychiatry and authorize Community Psychiatry to disclose my health information to my insurance company in order to obtain payment for services rendered to me. I understand that I am financially responsible for all charges not covered by my insurance plan, including copays and deductibles and no-show and late cancellation fees incurred by me, which are due at the time of my visit.

Balance under $100

I understand that Community Psychiatry requires me to keep a balance of under $100 in order to continue to be seen by my provider and that if I fail to do so, I may be terminated by my provider for non-payment.

Insurance

I understand that I am responsible for providing Community Psychiatry with accurate and complete insurance information. I also understand that I am required to notify Community Psychiatry of any changes in my insurance coverage and will be personally responsible for the cost of my care if I provide inaccurate or incomplete insurance information to Community Psychiatry or my coverage lapses.

I further understand that Community Psychiatry does its best to verify my insurance coverage and benefits before my appointment, but it is my responsibility to contact my insurance and confirm that CP is included in my insurance benefit plan.

Medi-Cal Patients

I understand that if I have a Medi-Cal plan I am only financially responsible for copay and share of cost amounts.

Payment for Minor Patient

I understand that the adult accompanying a minor to their appointment is responsible for payment for services. If a minor is unaccompanied by an adult to their appointment and did not alone consent to treatment, the minor's parent/guardian is responsible for sending the minor's copayment with them.

Payment by Check

I understand that after issuing Community Psychiatry two (2) checks that are unable to be processed for insufficient funds, Community Psychiatry will no longer accept checks as a form of payment from me and I will be charged for any fees assessed by Community Psychiatry for such invalid checks.

Past Due Balance

I understand that if I have a past due balance, I may establish a payment plan with Community Psychiatry, with which I must comply to continue to be seen by my provider. Accounts past due may be referred to a professional debt collection agency.

I understand that this Acknowledgement of Financial Responsibility will remain in effect until I provide written notice of cancellation to Community Psychiatry.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

If you are signing this Acknowledgment of Financial Responsibility as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

Signature _____ Date _____

Name _____

Credit Card AutoPay Authorization

I authorize Community Psychiatry to charge my credit card on file for amounts owed by me including co-pays, cancellations, and late fees. I understand that I will be sent receipts for credit card charges via mail or e-mail and that such charges will appear on my credit card statement. I understand that this Credit Card AutoPay Authorization will remain in effect until I provide written notice of cancellation to Community Psychiatry.

Patient Name

Patient Date of Birth

Credit Card Holder

Date

Credit Card Holder's Signature

Consent to Obtain Medication History

Community Psychiatry uses an electronic platform in its EHR to electronically prescribe medications to patients. Using this platform, providers can transmit prescriptions to a patient's desired pharmacy electronically from the point-of-care. NextGen also allows providers to obtain a patient's prescription medication history upon their consent. This information helps providers to identify potential medication issues, such as drug interactions and duplicate prescriptions.

I hereby authorize Community Psychiatry to request and use my prescription medication history collected from other healthcare providers, third-party payers (i.e. my insurance company), and pharmacies for treatment purposes.

I understand that this Consent to Obtain Medication History will remain in effect until I provide written notice of cancellation to Community Psychiatry.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

If you are signing this Consent to Obtain Medication History as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

Signature _____ Date _____

Name _____

E-Mail Authorization

I hereby request that Community Psychiatry and my provider, communicate with me regarding my treatment via electronic mail, or e-mail.

I understand that this means Community Psychiatry staff and my provider will transmit my protected health information, such as information about my appointments, diagnosis, medications, progress, and other individually identifiable information about my treatment, via e-mail. I understand there are risks inherent in the electronic transmission of information by e-mail, and that such correspondence may be lost, delayed, intercepted, corrupted, altered, rendered incomplete or undelivered. I further understand that any protected health information transmitted via e-mail pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error free and its confidentiality may be vulnerable to access by unauthorized third parties, neither Community Psychiatry nor my provider shall have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the e-mail of information by Community Psychiatry or my provider to me.

After being provided notice of the risks inherent in the use of e-mail to transmit protected health information, I hereby expressly authorize Community Psychiatry and my provider to communicate via email with me, which will include the electronic transmission of my protected health information. I understand that this E-Mail Authorization will remain in effect until I revoke it by submitting a notice to Community Psychiatry in writing.

I hereby authorize the transmission of my protected health information via e-mail as described above.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

Email Address _____

If you are signing this Consent to E-mail Authorization as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

Signature _____ Date _____

Name _____

Consent to Telemedicine

I hereby consent to the use of telemedicine by my Community Psychiatry provider. I understand that telemedicine involves the communication of my medical information, both orally and visually, to providers involved in my treatment who are located at a different site than me. I understand I have all of the following rights with respect to telemedicine:

Patient Choice. I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future treatment.

Access to Information. I have the right to inspect and receive copies of all medical information transmitted during a telemedicine consultation. I understand that my telemedicine provider will communicate my relevant health information to physicians and other health care practitioners involved in my treatment who are located in different offices or clinics in the state, such as my primary care physician or therapist.

Confidentiality. I understand that the laws which protect the confidentiality of medical information apply to telemedicine, that I will not be recorded, and that no information from my telemedicine consultations which identifies me will be disclosed to third parties without my consent.

Potential Risks. I understand that there are potential risks associated with telemedicine, including disruption or distortion in the transmission of medical information and unauthorized access to medical information generated, transmitted, and stored pursuant to the telemedicine consultation. I understand that telemedicine is an alternative to in-person treatment and my Community Psychiatry provider may recommend I discontinue telemedicine and receive in-person treatment in certain circumstances. I understand that telemedicine does not negate or minimize the risks that may be inherent to my illness or condition and that there may be other risks associated with telemedicine that are not listed here.

Benefits. I understand that I can expect benefits from telemedicine, but that no particular results can be guaranteed. I understand that telemedicine may provide me with access to psychiatry services that otherwise would not have been available to me.

Residing in California. I understand that I must be physically residing in California during my telemedicine appointments and agree to notify the front office staff or my provider if I will be out of the state during my scheduled telemedicine appointment so that the appointment can be rescheduled.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

_____

Email Address

If you are signing this Consent to Telemedicne as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

_____ _____

Signature Date

_____

Name

HIPAA

Notice of Privacy Practices

Privacy Officer – 916-576-7900

Effective Date: September 23, 2013

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 at the number 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. By law, the medical practice is required to ensure that your protected health information (referred to in this Notice of Privacy Practices as "PHI," "medical information" or "health information") is kept confidential. PHI consists of information created or received by the medical practice that can be used to identify you. It contains data about your past, present or future health or condition, the provision of health care services to you, or the payment for such services. The medical practice can use or disclose your PHI under the following circumstances:

1. Treatment. We may use or disclose your PHI in order to provide your medical care. For example, we disclose medical information to our employees and others within the medical practice who are involved in providing the care you need. In addition, we may share your medical information with other physicians or other health care providers who are not part of the medical practice and who will provide services to you. 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.

2. Payment. We may use and disclose PHI to obtain payment for the services we provide. For example, we might send PHI to your insurance company if required to obtain payment for services that we provide to you.

3. Appointment Reminders. We will use the home and work numbers that you provide to us in order to make or confirm your appointments. Unless you request otherwise, our staff will leave messages at these numbers with either appointment information or requests to contact us. We may also contact you to discuss your treatment, treatment alternatives or other health-related benefits or services we offer that may be of interest to you.

4. Health Care Operations. We may use and disclose your PHI as needed 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. 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. Under HIPAA, we may share your PHI with our "business associates" that perform administrative or other services for us. An example of a business associate is our billing services company. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your PHI.

5. Notification and Communication with Family. We may disclose to a family member, your personal representative or another person responsible for your care, the PHI directly relevant to that person's involvement in your care or about your location, your general condition or death. In the event of an emergency, we may disclose information to public service organizations to facilitate your care. 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.

6. Required by Law. As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law. For example, we may use or disclose PHI when the law requires us to report abuse, neglect or domestic violence, respond to judicial or administrative proceedings, respond to law enforcement officials or report information about deceased patients.

7. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for public health activities such as: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; and reporting to the Food and Drug Administration problems with products and reactions to medications.

8. 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.

9. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your PHI in the course of an 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.

10. Law Enforcement. To the extent authorized or required by law, we may disclose your PHI to a law enforcement official for purposes such as complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. If you are an inmate of a correctional institution or under the custody of law enforcement, we may release PHI about you to the correctional institution as authorized or required by law.

11. Public Safety/National Security/Protective Services. We may, and are sometimes required by law, to disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims and for other public safety purposes. Moreover, as authorized or required by law, we may disclose your PHI for national security or intelligence purposes or to authorized federal officials so they can provide protection to the President or other authorized persons or foreign heads of state.

12. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws.

13. Minors. If you are an unemancipated minor under California law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

14 Sale of PHI. We are prohibited from disclosing your PHI in exchange for direct or indirect remuneration unless we have obtained your prior authorization to do so.

15. Marketing. We must obtain your authorization before using or disclosing your PHI for marketing communications that involve financial remuneration. The authorization must disclose the fact that we are receiving financial remuneration from a third party.

16. With Authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Please note that although certain disclosures described above do not require your prior authorization under HIPAA, under California law we cannot make certain disclosures listed above unless you authorize the disclosure or the requesting party submits to you and us a signed, written request in accordance with Cal. Civ. Code §56.104. Moreover, additional limitations exist with respect to our ability to re-disclose certain records that we receive from outside providers.

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 not use or disclose PHI without your written authorization. If you do authorize this medical practice to use or disclose your PHI, 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, what limitations on our use or disclosure of that information you wish to have imposed and to whom the limits should apply. We reserve the right to accept or reject your request, unless you paid in full out of pocket for a healthcare item or service and you request that we do not notify your health plan that you have obtained such items or services. In that case, we must comply with your request. To the extent we have the right to accept or reject your request, we 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 post office box 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 and whether you want o inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. In such an event, we will notify you in writing of the reason for the denial, whether you

have the opportunity to have the denial reviewed and if so, the process for reviewing the denial. In most cases, there is an opportunity to review the denial. We will comply with the outcome of the review.

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. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your health information made by this medical practice for a period of up to six years. For example, we are not required to provide you with an accounting of disclosures made to you, for treatment purposes, made with your authorization and for certain other purposes. To obtain an accounting of disclosures, you must submit your request in writing. You are entitled to one accounting within any 12-month period. If you request a second accounting in a 12-month period, we may assess a reasonable fee.

6. Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

7. Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured PHI.

8. Paper Copy. You have a right to a paper copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

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 at the number listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend 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 of Privacy Practices. After an amendment is made, the revised Notice of Privacy Practices 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 of Privacy Practices posted in our reception area. We will also post the current Notice of Privacy Practices 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. You will not be penalized for filing a complaint.

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

Department of Health and Human Services

Office of Civil Rights

Hubert H. Humphrey Bldg.

200 Independence Avenue, S.W.

Room 509F HHH Building

Washington, DC 20201

Acknowledgment of Receipt of Notice of Privacy Practices

Privacy Officer – 916-576-7900

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and on the medical practice's website and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____

Patient Signature Date

_____ _____

Patient Name Patient Date of Birth

_____

Email Address

If you are signing this HIPAA Notice of Privacy Practices as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ❑ Parent
- ❑ Guardian
- ❑ Conservator
- ❑ Health Care Surrogate
- ❑ Power of Attorney for Health Care
- ❑ Executor / Administrator

_____ _____

Signature Date

_____

Name

Adolescent Consent Form

In California, patients who are between the ages of 12 - 17 are required to complete a Release of Information form.

In order to authorize Community Psychiatry, the treating provider(s), and its staff to disclose the patient's treatment information to and involve their parent(s) and/or guardian(s) in their care, please have the patient complete and sign the next form.

Authorization for Disclosure of Minor Patient's Health Information to Parent(s)/Guardian(s)

Patient Information

Patient Name: _____

Date of Birth (mm/dd/yy): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Recipient of Health Information

I hereby authorize Community Psychiatry, my treating provider(s), and its staff to disclose my health information to my parent(s) or guardian(s) named below:

(1) Parent/Guardian: _____Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

(2) Parent/Guardian: _____Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Purpose of Disclosure

The purpose of the disclosure of my health information is:

- ❑ Care Coordination
- ❑ Treatment Planning
- ❑ Legal
- ❑ Billing/Payment Activity
- ❑ Personal Use
- ❑ Other (Specify): _____

Information to be Disclosed

I authorize the following information to be disclosed:

- ❑ All of my health information and records, including information about my appointments, prescription medications and billing/payment for my care

OR

- ❑ Only the following information (specify): _____

_____

I authorize the disclosure of the following specially protected health information *(check and initial all that apply):*

- ❑ Inpatient/residential mental health treatment information
- ❑ Alcohol/drug treatment records
- ❑ HIV/AIDS test results
- ❑ Genetic test results
- ❑ Pregnancy test results
- ❑ Abortion
- ❑ Sexually transmitted or other communicable diseases

Expiration and Revocation

This Authorization will expire on the date that is five (5) years from the date of my signature below.

I understand that I may revoke this Authorization at any time by notifying Community Psychiatry in writing, except to the extent Community Psychiatry has already taken action in reliance on this Authorization.

Signature

I have read this form and I understand and agree to its terms. I authorize Community Psychiatry to disclose the information identified above.
I understand that Community Psychiatry cannot condition my treatment, payment, enrollment or eligibility for benefits on my provision of this Authorization. I understand

that information disclosed pursuant to this Authorization, except for alcohol/drug treatment records protected by 42 CFR Part 2, may be subject to redisclosure by the recipient and no longer protected by HIPAA. I understand that I have the right to receive a copy of this Authorization.

Patient Signature	Date
Patient Name	Patient Date of Birth

Authorization for Use or Disclosure of Health Information

Patient Information

Patient Name: _____

Date of Birth (mm/dd/yy): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Recipient of Health Information

I hereby authorize Community Psychiatry, its staff and providers, to:

- ❑ **Disclose to:** ❑ Therapist ❑ Primary Care
- ❑ **Request from:** ❑ Past Psychiatrist ❑ Other: _____

Person/Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of Disclosure

The purpose of the disclosure of my health information is:

- ❑ Care Coordination ❑ Treatment planning ❑ Legal
- ❑ Billing/Payment Activity ❑ Personal Use
- ❑ Other (Specify): _____

Information to be Disclosed

I authorize the following information to be disclosed:

- ❑ All of my health information and records, including, my medical and mental health history, lab results, diagnoses, treatment and prescriptions
  OR
- ❑ Only the following information (specify): _____

_____

I authorize the disclosure of the following specially protected health information *(check all that apply):*

- ❑ Inpatient/residential mental health treatment information
- ❑ Alcohol/drug treatment records
- ❑ HIV/AIDS test results
- ❑ Genetic test results
- ❑ Pregnancy test results
- ❑ Abortion
- ❑ Sexually transmitted or other communicable diseases

Expiration and Revocation

This Authorization will expire on the date that is five (5) years from the date of my signature below.

I understand that I may revoke this Authorization at any time by notifying Community Psychiatry in writing, except to the extent Community Psychiatry has already taken action in reliance on this Authorization.

Signature

I have read this form and I understand and agree to its terms. I authorize Community Psychiatry to disclose the information identified above.
I understand that Community Psychiatry cannot condition my treatment, payment, enrollment or eligibility for benefits on my provision of this Authorization. I understand

that information disclosed pursuant to this Authorization, except for alcohol/drug treatment records protected by 42 CFR Part 2, may be subject to redisclosure by the recipient and no longer protected by HIPAA. I understand that I have the right to receive a copy of this Authorization.

Patient Signature _____ Date _____

Patient Name _____ Patient Date of Birth _____

If you are signing this Authorization for Use or Disclosure of Health Information as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

❑ Parent ❑ Conservator ❑ Power of Attorney for Health Care
❑ Guardian ❑ Health Care Surrogate ❑ Executor / Administrator

Signature _____ Date _____

Name _____

Patient Health Screen (Adult)

Patient Last Name: **First Name:** **Date of Birth:**

1. Please state the reason for making this appointment:

2. Have you ever been diagnosed with any psychiatric conditions? ❑ Yes ❑ No *If yes, please list below:

3. Please list all current prescription medication, over the counter medications and/or supplements you are taking:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

4. Please list past medication that you discontinued and for what reason:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

5. Please list any allergies to medications:

6. Please list any current medical problems:

7. Please list any major surgeries:

8. Please tell us about your current/past providers:

Do you have a primary care provider?	Have you ever seen a psychiatrist before?	Are you currently seeing a therapist?
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Dr. Name: Dr. Phone #: Dr. Location: Last visit date:	Dr. Name: Dr. Phone #: Dr. Location: Last visit date:	Therapist Name: Therapist Phone #: Therapist Location: Last visit date:

9. Have you ever been hospitalized for psychiatric reasons? ❑ Yes ❑ No *If yes, please list below:

Hospital name	City	Admit Date	Discharge Date	Reason for Hospitalization

10. Is there a family history of psychiatric conditions? If yes, please psychiatric condition(s) and your relationship:

11. Please list your use of:

	Never	Once or Twice	Monthly	Weekly	Daily
Alcohol (For men, 5 or more drinks a day; For women, 4 or more drinks a day)	❑	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑	❑
Prescription Drugs for non-medical reasons	❑	❑	❑	❑	❑
Illegal drugs	❑	❑	❑	❑	❑

12. Please tell us more about yourself:

Education Level:	Employment:	Relationship:	Do you have children?
❑ Less than High School ❑ High School ❑ AA/AS ❑ Bachelors ❑ Masters ❑ Post Grad	❑ Employed ❑ Unemployed ❑ Student ❑ Stay at home parent ❑ Disabled	❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ Yes ❑ No If yes, please list how many:

13. Please list everyone who currently lives with you:

14. Are you currently dealing with significant financial problems (bankruptcy, foreclosure, large debt, etc.)?

❑ Yes ❑ No *If yes, please list below:

15. Are you currently dealing with significant legal problems (custody issues, divorce, DUIs, etc.)?

❑ Yes ❑ No *If yes, please list below:

16. Please list any other information you think is important for the provider to know:

Name of Patient

Today's Date

Patient's Signature

Patient Health Screen (Child/Adolescents)

Patient Last Name: **First Name:** **Date of Birth:**

1a. Please provide the names of parents and/or guardian(s):

1b. Relationship Status of parent's is: ❑ Never Married ❑ Married/Domestic Partnership ❑ Divorced ❑ Separated ❑ Widowed *If divorced, please answer 1c

1c. If divorced, what are the custody arrangements? *Please bring copy of custody documents

2. If child doesn't live with parent(s), please provide the name(s) of legal guardian and relationship to patient:

3. Please state the reason for making this appointment:

4. Has the child ever been diagnosed with any psychiatric conditions? ❑ Yes ❑ No *If yes, please list below:

5. Please list all current prescription medication, over the counter medications and/or herbal supplements the child is taking:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

6. Please list any psychiatric medications the child has tried in the past:

Medication	Dosage	Taking for how long?	Med helpful? / Concerns

7. Please list any known allergies to medications, food, or environmental allergies:

8. Please list any current medical problems the child has:

9. Please list any past major surgeries:

10. Please tell us about the child's current/past providers:

Does the child have a pediatrician/PCP?	Has the child ever seen a psychiatrist?	Is the child currently seeing a therapist?
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Dr. Name:	Dr. Name:	Therapist Name:
Dr. Location:	Dr. Location:	Therapist Location:
Dr. Phone #:	Dr. Phone #:	Therapist Phone #:
Date of last visit:	Date of last visit:	Date of last visit:

11. Has the child ever been hospitalized for psychiatric reasons? ❑ Yes ❑ No *If yes, please list below:

Hospital name	City	Admit Date	Discharge Date	Reason for Hospitalization

12. Where was the child born and raised?

13. What school does the child attend and what grade are they in?

14. Child Lives in: ❑ One Household ❑ Two household ❑ Multiple households

15. Please list everyone who currently lives with the child in each household and the relationship:

16. Please list parent(s)/guardian(s) highest level of education and current employment:

17. Is the family currently dealing with significant financial problems (bankruptcy, foreclosure, large debt, etc.)?

❑ Yes ❑ No *If yes, please list below:

18. Is the family currently dealing with significant legal problems (custody issues, divorce, DUIs, etc.)?

❑ Yes ❑ No *If yes, please list below:

19. Is there family history of psychiatric conditions in the child's family? If yes, please list who and what conditions:

20. Please list any other information you think is important for the provider to know:

Name of Parent/Guardian

Today's Date

Parent/Guardian's Signature

Name of Parent/Guardian

Today's Date

Parent/Guardian's Signature

Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date _____

	Not at all	Several Days	More than half days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	❑	❑	❑	❑
b. Feeling down, depressed, or hopeless	❑	❑	❑	❑
c. Trouble falling asleep	❑	❑	❑	❑
d. Feeling tired or having little energy	❑	❑	❑	❑
e. Poor appetite or overeating	❑	❑	❑	❑
f. Feeling bad about yourself or that you are a failure or have let yourself or family down	❑	❑	❑	❑
g. Trouble concentrating on things, such as reading the newspaper or watching television.	❑	❑	❑	❑
h. Moving or speaking so softly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❑	❑	❑	❑
2. If you checked off any problems on this questionnaire so far, 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**
	❑	❑	❑	❑

Generalized Anxiety Disorder 7-item (GAD-7)

Patient Name _____ Date _____

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	❑ 0	❑ 1	❑ 2	❑ 3
2. Not being able to stop or control 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. Becoming easily annoyed or irritated	❑ 0	❑ 1	❑ 2	❑ 3
7. Feeling afraid as if something awful might happen	❑ 0	❑ 1	❑ 2	❑ 3
Add the score for each column				
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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
	❑	❑	❑	❑

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.