GLENDALE
MENTAL
HEALTH
GlendaleMentalHealth.com

Glendale Mental Health Inc.
800 S Central Ave. - Rm 307
Glendale, CA 91204

Tel: (818) 396-0917
Fax: (818) 646-1441
info@glendalementalhealth.com

NEW PATIENT REGISTRATION FORM

- First Name: _____ • Middle Name: _____ • Last Name_____
- Date of Birth: _____
- Sex: M / F
- Marital Status: _____
- Street Address: _____
- City, State, Zip: _____
- Email Address: _____
- Phone Numbers (May we leave a message? Y or N):

Home: _____
Work: _____
Cell: _____

MEDICAL AND REFERRAL INFORMATION

Name of Primary Care Physician: _____
Telephone Number of Primary Care Physician: _____
Address of Primary Care Physician: _____
May I contact your health care provider in the future? _____
Who referred you to our practice? _____
Please list names and contact information for any doctors that have been significantly involved in your care over the last ten years.

* _____
* _____
* _____
* _____

Emergency Contact

Who should we contact in case of emergency?_____
Relationship to you? _____
Home and Cell Phone Numbers: _____

Medical History

Current medical problems: _____
Past medical problems (with dates):

- _____
- _____
- _____
- _____
- _____
- _____

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Past surgical history (with dates):

- _____
- _____
- _____
- _____
- _____
- _____

Family Medical/Mental Health/Drug/Alcohol History (siblings, parents, children, aunts/uncles):

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Current medications (name/dosage/frequency/reason for taking the medication):

- _____
- _____
- _____
- _____
- _____

Allergies to medications and reaction: _____
Supplements, vitamins, or herbs: _____
Exercise (frequency & type): _____
Tobacco use: _____

Drug or alcohol use (include what drugs, amount and frequency): _____
_____
_____
_____
_____

Current Issues (include symptoms & duration):_____
_____
_____
_____
_____

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AUTHORIZATION OF RELEASE PATIENT HEALTH INFORMATION FOR TREATMENT, BILLING OR HEALTHCARE OPERATIONS

I understand that Glendale Mental Health reserves the right to change their notices and practices, and I will be given new notification if this occurs.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing. I understand that the Glendale Mental Health staff are not required to adhere to these restrictions requested in the event of a potentially life threatening emergency.

Records may be needed in order to process a claim for medical services. I authorize providers at Glendale Mental Health to release information needed for billing purposes to entities that may provide services pertaining to my physical visit, such as laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of billing, treatment, or pertinent healthcare operations.

Patient/Guardian Signature_____ Date _____

Patient/Guardian Printed Name_____

I authorize Glendale Mental Health to discuss my psychiatric/mental health care to any and all past or present treating health professionals as well as the following (*please list* any friends or family members that you may want to have included in your treatment):

Names: _____

I am aware that this information may pertain to my psychiatric condition and/or treatment of substance abuse. I execute the release of this information.

Patient/Guardian Signature_____ Date _____

Patient/Guardian Printed Name_____

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NOTICE OF OFFICE POLICIES, PROCEDURES AND CONSET OF TREATMENT

Travelling Out of State:

Should you leave the state, your provider will not be able to continue to prescribe medication. If you are going on vacation, please call your provider with enough notice so that he or she can give you enough medication prior to your trip.

Privacy and Release of Information:

Services that you receive in this office are confidential, except in the following circumstances listed below:

· Threats of harm to yourself or others.
· Abuse of a vulnerable adult, child, or developmentally disabled person.
· A court order to release information.
· Subpoena of treatment records by an attorney. If you do not want this information released, you must obtain a protective order from the court within fourteen days of the request.
· If you will be submitting a claim to your health insurance, we may be required to prove information to your health plan, including some or all of your record of treatment, in order for your carrier to pay for services. By signing this form, you consent to release this information to your health plan.
· If you are involved in a child custody litigation at any time in the future, the court may order release of information about your treatment.

In circumstances other than these, I will not release information about your treatment without your authorization.

Patient Records:

A secured electronic record is kept of services you receive in this office. You have the right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize, in writing, that copies of the record be released to entities you designate. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider.

Methods of Communication and Execution of Clinical Care:

You can generally expect a return call within one business day that a message is left. Should there be an emergency or concern for imminent health or the safety of yourself or another person, please call 911 or go to the nearest emergency room immediately.

Hospitalization:

Should you require hospitalization, please go to your nearest emergency room or dial 911. Staff at Glendale Mental Health do not have admitting privileges at the hospital. Should you need to be admitted, they can communicate with the inpatient treatment team to let them know about your prior treatment.

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Secure Messaging:

Patients are offered the opportunity to use secure messaging (similar to email) with providers through patient fusion. Should a patient elect to do this, please keep in mind that this service should only be used for non-emergent matters as messages are not checked daily. This service is HIPAA compliant.
Should there be an emergency, the best option is call 911 or go to the nearest emergency room.

Patient Signature_____ Date_____

Patient Printed Name_____

Consent for email/text messages:

I understand that Glendale Mental Health cannot guarantee the confidentiality of any email communications and will not be liable for improper disclosure of confidential information and/or breaches in confidentially caused by me or a third party. I understand that Glendale Mental Health has no control over the security or management of my individual email service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient.

I further understand and agree that: email will not be used in emergencies and I agree to call 911 in the event of an emergency, emails will be answered within a maximum of 7 business days and that a prompt reply may not be available during weekends or holidays, I must include my full name and date of birth in every email message I send, I understand and agree that providers may choose to stop electronic communications with me at any time, and I understand that the confidentiality of my individually identifiable health information may be compromised when such is sent through email. I agree to the requirements listed above and hereby voluntarily request and consent to communicate with physician and/or office personnel by email or text.

Patient Signature_____ Date_____

Patient Printed Name_____

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Insurance Benefits and Patient Responsibilities for Fees:

Glendale Mental Health does not participate as a contracted provider for any insurance company and does not do insurance billing, but can provide you with a detailed receipt that you may submit to your insurance company. They may or may not then provide some direct reimbursement to you. Payment is due at the time the service is rendered. Glendale Mental Health accepts cash, check, and major credit cards.

Cancellation Notice, Cancellation Fee and No-Show Policy:

Our clinic requires **24 business hours notice** for cancellations. Therefore, cancellations for a Monday visit must be made early the Friday prior. Missed visits, no-shows or late cancellations will be charged the **full fee** of the scheduled session (for new patients as well as follow up patients).

Phone calls longer than ten minutes will be billed at the next highest rate level (i.e. less than thirty minutes will be billed for thirty minutes, greater than thirty minutes but less than fifty minutes will be billed at fifty minutes). Any outstanding fees will be charge to the card designated on this form.

Fee Agreement:

Description of Procedure	Minutes	Fee
60-Min Initial Consultation	**60**	**$380**
90-Min Initial Extended Consultation	**90**	**$560**
15-Min Medication Management Visit	**15**	**$95**
25-Min Medication Management Visit	**25**	**$180**
50-Min Medication Management Visit	**50**	**$380**
50-Min Psychotherapy Visit or Session	**50**	**$380**

Forms/Letters: $50 (this may vary based on the amount of time involved)

I understand and accept the terms of the Fee Agreement, Cancellation Fee, and No-Show Policy as outlined above and authorize Glendale Mental Health to charge my credit card accordingly.

Credit Card Number: _____
Credit Card Type: _____
Expiration Date: _____ Security Code:_____

Name on Credit Card: _____
Billing Street Address: _____
Billing City, State, Zip: _____
Phone Number: _____
Email: _____
Signature: _____
Date:_____

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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 right 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 shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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.

Filing by Physician 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 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 by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this 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 Duly Authorized Representative Signature (Date)

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

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
Patient's Representative's Signature (if applicable)(Date)

_____
Print Name and Relationship to Patient

A signed copy of this document should be given to the patient. The original copy will be archived in the patient's medical file.