Desert Marriage and Family Counseling Inc.

PERSONAL INFORMATION FORM

Name: ____

Date of Birth:____________Social Security No._____________________________Sex:________

Marital status: Single / Married / Divorced / Widowed / Separated / Domestic Partner

Address:____________________________________City____________________Zip_________

Home phone:______________________Cell phone: __________________________________

Work phone:_______________________Email_____________________________________

Form of preferred contact: Text Message / Phone Call / Text and Phone Call, MARK with * next to the best number where we can reach you)

Employed By:_________________________________Occupation: ________________________

Business Address:______________________________City___________________Zip_________

Emergency Contact Person

Name_______________________________________Phone_____________________________

Primary Care Doctor

Name_______________________________________Phone_____________________________

How did you hear about us?____

Referred by:____

May I thank them? yes_________no__________

If yes then please fill out the Authorization for Release of Information form so we can thank them.

Signature:____Date:__________________

Phone: 760-777-7720 Fax: 760-452-8532

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Desert Marriage and Family Counseling Inc.

PATIENT MEDICAL HISTORY

Current Medications	
Medication	Prescribed Dosages

Past Psychiatric History (Mental health and chemical dependency)

Prior Outpatient Therapy			
Previous practitioners	Dates of treatment	Previous treatment intervention	Response to medications

Family Mental Health or Chemical Dependency History

Social Interaction Information
Support Systems (family members etc.):
School/Work Life:
Marital History:
Legal History:
Military History:
Spiritual :

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Substance Use/Abuse History (complete for all patients 12 and over)				
Substance	**Amount**	**Duration**	**First Use**	**Last Use**
Caffeine				
Tobacco				
Alcohol				
Marijuana				
Opioids/Narcotics				
Amphetamines				
Cocaine				
Hallucinogens				
Others				

Do you have any concerns about your sexual behavior? (Yes / No)

Would you care to discuss this matter with your clinician? (Yes / No)

Do you have any concerns about your gambling habits? (Yes / No)

Would you care to discuss this matter with your clinician? (Yes / No)

Do you have any concerns about your eating habits? (Yes / No)

Would you care to discuss this matter with your clinician? (Yes / No)

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CONSENT FOR TREATMENT

I hereby authorize and request____to carry out psychiatric and psychological examination, evaluation, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that these are subject to my agreement. I fully understand that while the course of my treatment is designed to be helpful, ____ can make no guarantees whatsoever about the outcome of my treatment. I also understand that the psychopharmacotherapeutic process can initiate and bring up uncomfortable feelings and reactions including, but not limited to anxiety, sadness, anger and physical side effects. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be jointly worked on between my therapist and me.

Patient____**Date**________

GENERAL CONSENT TO TREATMENT IN CASE OF DEPENDENT/CHILD/MINOR

I am the legal guardian and/or representative of the patient and on the patient's behalf legally authorize ____to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Signature of Guardian/Legal Representative,_____________________________________**Date**________

Relationship of Patient____

Desert Marriage and Family Counseling Inc.

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OFFICE POLICIES

1.Confidentiality:

Confidentiality is essential for effective psychiatric treatment. No information will be released without your consent, except for the following situations: By law, I am required to report suspected child or elder abuse, domestic violence, and take action when a patient is considered to be danger to themselves or other.

2. Payment Policy:

Scheduled appointment times are reserved specifically for you. **Failure to provide 24 hours cancellation notice or missed appointments will be billed and your credit card will automatically be charged.**

Additional fees not coveredby your insurance policy can be charged. Some of these fees are not know until notification is sent to DMFC and/or you from the insurance company.

A credit card will be held on file to guarantee payment but will not be charged without notification.

3. Additional Services:

Services required outside of treatment session will be charged a fee. These could include consultations with other professionals, court appearances, and document preparation such as completing legal forms, conservatorship petitions, letters, etc.

"I have read, understand and agree to the above policies."

Patient Name____

Signature of Patient or Responsible Party
(if patient is a minor or service are being paid by other party)

Responsible Party Name____

Signature:______________________________Date______________

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Desert Marriage and Family Counseling Inc.

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CREDIT CARD INFORMATION

I,____authorize Desert Marriage and Family Counseling, Inc. to charge my credit card for outstanding balances on my account due to late cancellations, no show appointments, returned checks, credit cards charge backs and fees not collected from original time of service.

Name on Card,____

Credit Card #

Visa |MasterCard | Discover | Amex

Exp Date : Security Code : Billing ZIP:

Billing Address : ____

CITY__________________________________STATE________________________________ZIP__________

Would you like a receipt emailed to you? Yes | No

Email Address: ____

PLEASE PRINT CLEARLY

Signature :____Date: _____________________

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Desert Marriage and Family Counseling Inc.

Insurance Information Sheet

Date: ____________________

Client Name:____Date of Birth:______________

SSN : | | | | | | | | | |

Name of Insured:____Date of Birth: ______________

SSN of Insured: | | | | | | | | | |

Insurance Co. Name:____

Tele:__________________________________Policy# | | | | | | | | | | | | |

Mental Health Insurance Carrier : ____

EAP Auth:_____________________________How many sessions: ____________________

Do you have a deductible? Yes__________No_________Amount $__________________

Do you have a co-payment? Yes_________No_________Amount $__________________

Does your insurance plan require pre-authorization? Yes__________No__________Unknown__________

Authorization Number:____

PLEASE HAVE YOUR INSURANCE CARD AVAILABLE FOR PHOTOCOPYING

Sign below to authorize billing of Insurance carrier

Client Signature:____Date: ___________________

I hereby give consent for release of clinical/psychological information as needed to be given to my insurance carrier upon their request for the purpose of payment on my account. I realize that I am responsible for obtaining any pre-authorizations. I also understand that I am financially responsible for any balance due if my insurance denies payment for any reason.

Client Signature:____Date: _________________

NOTE ON INSURANCE: DMFC Bills for most insurance as a courtesy to our patients. We are "out of network" with most insurance companies, therefore your out of network benefits apply. We bill for many of our patients but do not contract for fees at network rates. You might be billed for the difference in rates between the two. Generally, we collect or fee at time of service, and before insurance is billed. Our goal is to be helpful and assist you in accessing your insurance benefits no matter which company you are insured with. There are "NO CHARGES" with this service, but it is courtesy provided but we are not required to perform.

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Desert Marriage and Family Counseling,

PATIENT ARBITRATION AGREEMENT

The contract below 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 that a suit in court. I believe the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts. By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings. Of course, my goal is to provide medical care in such a way as to avoid any such disputes. I know that most problems begin with communication. Therefore, if you have any questions about your care, please ask me.

By signing this agreement, the patient agrees with the provider that any dispute between you and Desert Marriage and Family Counseling, Inc. and any dispute relating to medical services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whomever made (including, to the full extent permitted by applicable law, third parties who are not signatories to this agreement) shall be resolved by binding arbitration. Any award of the arbitrator(s) may be entered as a judgment in any court having jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective and the remainder of the agreement shall remain effective. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

This agreement binds 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. This provision for arbitration may be revoked by written notice delivered to the physician within 30 days of signature.

If the 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/Responsible Party Initials: _______

The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the physician, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

Patient Name____

Signature of Patient or Responsible Party (if Patient is a Minor)_________________________________**Date:** __________

Desert Marriage and Family Counseling Inc.

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HIPPA NOTICE OF PRIVACY PRACTICES

A federal law, known as the "HIPAA Privacy Rule" requires that we tell you how we may use and give out personal health information about you to others. This summary will tell you what out Privacy Notice contains.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION

We may use and share personal health information that is protected (PHI) to you or your personal representative.

We may use and share this information:

- For healthcare treatment that doctors, nurses and other clinicians give you
- For certain business activities called "health care operations" and
- For payment.

Some examples of how we may use and share PHI about you without your written permission including sharing information:

- To report abuse, neglect, or domestic violence
- To prevent a serious threat to your other's health or safety
- To prevent public health problems
- To agencies that audit, investigate and inspect health programs for the public's health
- For lawsuits and other legal proceedings
- For research
- To the Government for specialized purposes, such as military or national security; and
- For worker's compensation.

YOUR RIGHTS

You have the following rights as described in our Notice:

- The right to ask us if we will put more limits on the way we use and share PHI about you
- The right to share confidential communications from us
- The right to see and get a copy of PHI about you
- The right to ask us for a report that describes how and with whom we share PHI about you.

If you have any questions regarding your rights or privacy, please inquire with our office or reference http://www.hhs.gov/ocr/privacy.

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HIPPA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have read a copy of this HIPAA Notice of Privacy Practices. I further acknowledge that I may obtain a copy if requested.

PATIENT (PRINT) ____

SIGNATURE____Date_________________

FOR PATIENTS UNDER THE AGE OF 18

RESPONSIBLE PARTY (PRINT) ____

RELATIONSHIP TO PATIENT____

SIGNATURE____Date_________________

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Desert Marriage and Family Counseling Inc.

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: ______________________________________ **Date of Birth** ______________________

Address (Mailing): ____

Phone: ____

I authorize Desert Marriage and Family Counseling to use or disclose information from my mental health record, which may include information about psychiatric diagnosis, treatment and substance abuse issues to:

Name: ____ Phone: __________________________

Address:______________________________________ FAX: ____________________________

____

Dates of Treatment: ____

Information to be released (Please describe) ____

Purpose of Disclosure ____

1. I understand that, unless withdrawn, this authorization will expire 1 year from the date of signature. A photocopy of this form will be considered as valid as the original.

2. I understand that I may revoke this authorization at any time by notifying Desert Marriage and Family Counseling at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.

4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

5. My health care and payment for my health care at Desert Marriage and Family Counseling will not be affected if I do not sign this form.

6. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

____ ____________________________

Signature of Patient **Date**

OR ____ ____________________________

Signature of Parent/Legal Guardian/Authorized Person **Date**

Relationship to Patient: ____