So Cal Psychiatric Care

WELCOME TO SO CAL PSYCHIATRIC CARE

Patient Name____

We welcome you and your family members to our practice. We will do everything in our professional capacity to make the treatment as productive as possible. Please find displayed patient's rights and responsibilities in our office.

It is understood that all information between patient and Psychiatrist/Therapist is held in strict confidentiality, and Psychiatrist/Therapist will not release any of that information unless permitted by law, or;
1. It is agreed upon in writing and complies by state law
2. The patient presents an imminent danger to self or others
3. Child/Adult neglect is suspected
4. Is necessary for continuity of care
5. A judge chooses to subpoena the records
6. As requested by a court appointed attorney for a child involved in court proceedings

Patient consent to release of information
I consent to information release about my (or my child's) case with the referral source and co treating health care providers and facilities for purpose of treatment, payment and Health Care Operations. I further consent to the release of information to my health plan for claims, certification/ case management/ quality improvement and other health plan purpose.

General consent for treatment
I further authorize and request that my psychiatrist/therapist carry out psychological examinations, treatment and/or diagnostic procedures that now or during the course of my care as a patient is advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may be at times difficult and uncomfortable.

General consent for treatment (for minor)
On patient's behalf, (the legal guardian or Legal Representative) authorize SCPC to deliver mental health services to the patient. I understand that all policies stated on this page apply to the patient. I accept that child's records are confidential and that by law, I cannot have access to the child's records if such access would be deemed as detrimental to the child.

Patient/Legal Representative Name_______________________________

Date___________________ **Patient/Legal Representative Signature**_______________________________

Provider Name_______________________________

Date___________________ **Provider Signature**_______________________________

License No._______________________________

So Cal Psychiatric Care

PATIENT INFORMATION SHEET

Last Name ________________________ First Name________________________

MI _______ Gender_________ Marital Status_______

DOB_______________SS No.____________________

Address____

City______________________ ST______ Zip_________

Phone____________________Cell________________________Wk______________________

Birth State ___________________ Race _________________________

Occupation___________________________ Employer________________________________

Address______________________________City____________________ST_______Zip______

Phone______________________Ext_____________

Relative/Emergency
(Please list two)

Last Name_____________________________ FirstName_________________________

Relation_____________________________ Phone_____________________________

Last Name ____________________________ First Name __________________________

Relation ____________________________ Phone _____________________________

Insurance
Primary___________________________________

☐ HMO ☐ PPO ☐ POS ☐ Other

Insurance Address____

Effective Date_______________________ ID_______________________________

Group______________________________ Phone______________________________

Policy Holder____________________________ DOB________________ SS No.__________________

I certify that I, and or my dependent(s), have insurance coverage with ________________________________ and assign directly to Dr. Sathpathy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my healthcare information and disclose such information to the above- named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will end when my current treatment plan is completed.

Patient/Legal Representative Name________________________________

Date____________________ **Patient/Legal Representative**

Signature________________________________

Provider Name________________________________

Date____________________ **Provider Signature**________________________________

License No.________________________________

9888 Carroll Center Road Suite 218, San Diego, CA 92126
Office (858) 935-9104 I Fax: (858) 935-9103

So Cal Psychiatric Care

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIANS AND HEALTHCARE PROVIDERS

PATIENT SECTION

Patient Name____DOB___________________

Patient Address____

City_______________________State_________________________Zip________________________

Name of Patient's Primary Care Physician (PCP)____

PCP's Address____

City_______________________State_________________________Zip_______________________

PCP's Phone No.________________________________

I AUTHORIZE the disclosure of confidential mental health information between my Mental Health Provider and my Primary Care Physician/Healthcare Provider. I give permission to disclose diagnoses and treatment information about my child or me for the purposes of continuity of care. I understand an expressly authorize the release of information related to any Substance Abuse or HIV status. This authorization is valid unless revoked by me in writing at any time.

Patient/Legal Representative Name_______________________________

Date____________________ **Patient/Legal Representative**

Signature_______________________________

I REFUSE to authorize the release/exchange of any behavioral health and medical information between my Mental and Behavioral Health Provider and my Primary Care Physician/Healthcare Provider to promote the continuity of my behavioral health care and my general medical care.

Patient/Legal Representative Name_______________________________

Date____________________ **Patient/Legal Representative**

Signature_______________________________

BEHAVIORAL HEALTH PRACTITIONER SECTION

Dear______________________________

I saw your patient for an initial evaluation on_______________________

____

Current diagnoses are____

(For Psychiatrists) I have prescribed the following medication and dosages

____

____

Outpatient care is appropriate at this time and the initial treatment will consist of the following

☐ Medication Management ☐ Individual Psychotherapy

☐ Family/Conjoint Therapy ☐ CD IOP

Inpatient care/partial hospitalization is necessary and patient has been referred to

____

If you need additional information, please contact me at So Cal Psychiatric Care (859) 935-9104

Provider Name______________________________

Date___________________ **Provider Signature**______________________________

License No.______________________________

So Cal Psychiatric Care

FINANCIAL TERMS AGREEMENT

Patient Name____

I understand that SCPC is performing a courtesy for me by billing my insurance company and it is ultimately my responsibility to know my insurance benefits and coverage. Upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my provider will be paid directly by the carrier. SCPC will make every effort to assist me in getting my claims correctly, however, SCPC may need to contact me to have me help resolve claim issues with my insurance company. I will be responsible for any applicable deductibles and co- payments at the time of service. I agree to make these payments at each appointment. I do have the option of paying cash, due at time of service, and then billing my insurance company directly for reimbursement. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered.

i also understand that will be responsible for a charge of $60 for any missed appointment if not cancelled prior to 48 hours of appointment time. SCPC will have access to my payment information so as to deduct the amount upon missed appointment. By signing this agreement give permission to SCPC to deduct the amount as mentioned above.

Patient/Legal Representative Name_____________________________

Date___________________ **Patient/Legal Representative**

Signature_____________________________

Provider Name_____________________________

Date___________________ **Provider Signature**_____________________________

License No._____________________________

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