SCPC TMS PATIENT FORMS

Please complete the forms below and submit one day prior to your appointment.
If you have any questions, please call us at (858) 666-0212

WELCOME TO SO CAL PSYCHIATRIC CARE

Patient Name | Patient Email | Patient Phone

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

PATIENT INFORMATION SHEET

First Name

Last 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)

First Name

Last Name

Relation

Phone

First Name

Last 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

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 I 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 any balances due from us. By signing this agreement I 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