PSYCHIATRIC wellness center

8307 Brimhall Rd. Ste.1706
Bakersfield, CA 93312
P: (661)471-2408 F: (661)471-2414

8329 Brimhall Rd. Ste. 804
Bakersfield, CA 93312
P: (661)431-1555 F: (661)381-7670

6313 Schirra Ct. Ste. 1
Bakersfield, CA 93313
P: (661)323-6410 F: (661)323-0634

www.psychwellnesscenter.com

PATIENT INTAKE INFORMATION
CONTACT INFORMATION

Everything in BOLD must be filled-in (with blue or black ink ONLY)

PATIENT NAME: _____ SEX: MALE / FEMALE

BIRTHDATE: _____/_____/_____ SOCIAL SECURITY NO: _____-_____-_____

HOME PHONE: _____ CELL:_____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL *(optional)*:_____

REFERRED BY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

POLICY/ID NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER'S NAME: _____ **BIRTHDATE: _____/_____/_____**

RELATION TO PATIENT: _____ **SS#**:_____-_____-_____

SECONDARY INSURANCE *(Include any Medi-Cal plans)*:_____

POLICY/ID NUMBER: _____ GROUP NUMBER: _____

SUBSCRIBER'S NAME: _____ **BIRTHDATE: _____/_____/**

RELATION TO PATIENT: _____ **SS#**:_____-_____-_____

AS PATIENT, OR AS LEGAL GUARDIAN OF MINOR PATIENT, I AGREE TO PAY FOR ALL SERVICES RENDERED. THIS OFFICE MAY BILL MY INSURANCE CARRIER AS NEEDED. I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES. I AUTHORIZE THIS OFFICE TO RELEASE MY INFORMATION TO PROCESS ANY REQUESTS.

- ❑ For patients under 18 years of age: *I CERTIFY THAT I HAVE LEGAL GUARDIANSHIP OF THE PATIENT AND I AM AUTHORIZED TO MAKE HEALTHCARE DECISIONS FOR THE PATIENT.*

SIGNATURE: _____ DATE: _____/_____/_____

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I HEREBY AUTHORIZE KERN PSYCHIATRIC HEALTH AND WELLNESS (KPHW) DBA PSYCHIATRIC WELLNESS CENTER TO RELEASE ALL MEDICAL INFORMATION TO THE ABOVE NAMED INSURANCE CARRIER OR TO A DESIGNATED ATTORNEY FOR THE PURPOSE OF CLAIMS ADMINISTRATION AND EVALUATION UTILIZATION REVIEW AND FINANCIAL AUDIT. THIS AUTHORIZATION REMAINS VALID AND EFFECTIVE FROM THE DATE OF SIGNING UNTIL REVOKED IN WRITING.

I UNDERSTAND THAT I MAY REQUEST A COPY OF THE AUTHORIZATION.

I READ THIS AUTHORIZATION AND UNDERSTAND IT.

I HEREBY ASSIGN TO KPHW ALL MONEY TO WHICH I AM ENTITLED TO FOR MEDICAL AND/OR EXPENSES RELATIVE TO THE SERVICES RENDERED BY KPHW, BUT NOT TO EXTEND MY INDEBTEDNESS TO SAID PHYSICIAN AND/OR SURGEON.

IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE ABOVE NAMED INSURANCE COMPANY OVER AND ABOVE MY INDEBTEDNESS WILL BE ASSESSED TO MY ACCOUNT.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO KPHW FOR CHARGES NOT COVERED BY THIS AGREEMENT.

I FURTHER AGREE IN THE EVENT OF NON PAYMENT TO BEAR THE COST OF COLLECTIONS AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

SIGNATURE: _____ DATE: _____/_____/_____

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TREATMENT CONSENT

I, _____ authorize and request that Psychiatric Wellness Center provides treatment which is advisable in the course of my care as a patient. The frequency and type of treatment will be decided between my provider and me.

I understand that if any medication is prescribed during the course of my treatment that any risk and side effects will be explained to me at the time and that I may request to stop medication at any time. I agree to discuss the decision to discontinue medication and the possible side effects that may occur from this decision with my provider before acting upon this decision.

I understand that maximum benefit will occur with consistent attendance and compliance with treatment (medications. counseling, etc.) as suggested by my provider, but no guarantee of the results of treatment may be expected.

Important Information to Patients

Please be advised that we **do not** provide evaluations (diagnoses) or treatments for litigation purposes. Litigation purposes would include criminal cases, divorce, personal injury and emotional distress types of cases, among others. If you are seeking evaluation and treatment for a litigation purpose, we recommend that you retain a physician and/or psychologist who perform such legal evaluations and treatment.

The providers of the Psychiatric Wellness Center **do not** provide litigation evaluations or treatments; our purpose is strictly to assist YOU.

_____ I have read and fully understand this Treatment Consent form.

SIGNATURE: _____ DATE: _____/_____/_____

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PRACTICE GUIDELINES

The following is a list of guidelines that will allow for efficient use of your time and that of the practice's time.

Please authorize the specific practices by **initialing** in the spaces provided and signing below.

1. _____ I give permission to Psychiatric Wellness Center (PWC) to remind me by telephone of my appointments. This permission extends to allowing PWC to leave a reminder of my appointment on my message machine or voicemail.

2. _____ I give permission for the provider to use my first name in the waiting room when calling me back for my session.

3. _____ I give permission to fax any essential information to my primary physician, pharmacy, HMO, insurance provider, hospital, and/or other medical provider involved in my treatment (i.e. faxing a refill authorization to your pharmacy).

4. _____ I understand that if I am more than **10 minutes late** to an appointment the appointment will be rescheduled and a **No Show Fee** will be charged to my account, at the provider's discretion.

5. _____ I understand that if the patient is a minor (under 18 years of age), a parent, guardian or authorized person must accompany them to the appointment.

SIGNATURE: _____ **DATE:** _____/_____/_____

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MISSED APPOINTMENT AGREEMENT

INITIALS AND A SIGNATURE SIGNIFIES AN UNDERSTANDING AND AGREEMENT TO THE FOLLOWING:

_____ It is my responsibility to notify Psychiatric Wellness Center 24 hours prior to the scheduled appointment if I intend to cancel or reschedule that appointment. We do not accept cancellations through our answering service.

_____ I will be billed for all missed appointments, late cancellations, and late rescheduled appointments at the standard office rate of $50.00 (30-45 min. scheduled new evaluations), $50.00 (45-60 min. scheduled follow-ups), or $35.00 (15-30 min. scheduled follow-ups). Any missed appointments, late cancellations, and late rescheduled appointments for psychological/neuropsychological testing, two hours in length, will be charged a standard office rate of $100.00.

_____ I agree to pay this amount in the event that I miss an appointment or fail to cancel or reschedule 24 hours prior to the scheduled appointment.

_____ Payment of these above mentioned fees is required before another appointment can be made.

SIGNATURE: _____ DATE: _____/_____/_____

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Medication Compliance Contract

Patient Name:_____**Date of Birth**:_____

I, the undersigned, agree to be in compliance to all medication management appointments and treatment plans with Psychiatric Wellness Center. I understand that my physician is requiring me to return as medically needed for these appointments (per his or her discretion).

1. I will take my medication as prescribed by my doctor; I will talk with my doctor before changing dosage.
2. I will not accept the same prescriptions from any other doctors.
3. I will take care of my medications. My doctor will only replace lost, stolen or damaged prescriptions at his/her discretion, and I will be charged a $15 refill fee.
4. My doctor will only approve early refills at his/her discretion, and I will be charged a $15 refill fee.
5. My doctor will **NOT** approve refills when the doctor's office is closed.
6. I will request all refills by calling my pharmacy and requesting that they fax the request to the facility during doctor's office hours at least 5 days prior to taking my last dosage of medication.
7. I know that my doctor may change or stop my medication if it does not relieve my symptoms.
8. I understand that if I miss my scheduled appointment I **MUST** make a follow up appointment and my medications will only be refilled up to that date, and I will be charged a $15 refill fee.
9. I understand that I will be required to be seen at least every 3 months to continue services.
10. I understand that if I have not been seen in 6 months that no refills will be given and I will have to schedule a new patient appointment.

I understand that if this contract is broken at any time or if my physician feels that I am abusing any prescription medications, services with PWC will be discontinued immediately and a referral to another facility will be given along with a final 30 day supply of medications.

*I agree to **ALL** of the above compliances within this contract with PWC.

SIGNATURE: _____ DATE: _____/_____/_____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices of Psychiatric Wellness Center*** Our ***Notice of Privacy*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by writing to Psychiatric Wellness Center 8329 Brimhall Rd. Ste. 804 Bakersfield, CA 93312.

I acknowledge receipt of the ***Notice of Privacy Practices of Psychiatric Wellness Center.***

SIGNATURE: _____ DATE: _____/_____/_____

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization. This authorization expires **1 year** after the date it's signed, unless otherwise specified:_____-_____-_____ ***(Expiration date)***

Name of patient:_____ **Date of birth**: _____-_____-_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize PSYCHIATRIC WELLNESS CENTER

☐ To SEND records TO: _____
Person/Organization authorized to receive the information

_____
Address - street city state zip code Phone

☐ To RECEIVE records FROM: _____
Person/Organization authorized to receive the information

_____
Address - street city state zip code Phone

Include the following information:

☐ **ALL** health information pertaining to my medical history, mental or physical condition and treatment:

☐ **OR** Only the following records or types of health information (including any specific date ranges):

_____

_____

I specifically authorize release of the following information (check as appropriate):

Mental Health treatment information _____***(Initial here)***

HIV test results _____ *(Initial here)*

Alcohol/drug treatment information _____ *(Initial here)*

SIGNATURE: _____ DATE: _____/_____/_____

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**A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.*

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request; OR ☐ Other:

_____

_____

Limitations, if any:

_____

_____

MY RIGHTS

*I may inspect or obtain a copy of the health information that I am disclosing by signing this form.

*I have a right to receive a copy of this authorization.

*I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
8329 Brimhall Rd. #804 Bakersfield, CA 93312.

*Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Today's date:_____

_____

Patient Name *Date of birth* *Patient Telephone Number*

_____

Patient Address *City* *State* *Zip Code*

*If signed by other than patient, indicate authority*_____

SIGNATURE: _____ DATE: _____/_____/_____

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Coordination of Care Form

With your permission, this information will be forwarded to your healthcare provider.

Practitioner/Provider Information		**Patient Information**
Provider Name:		**Patient Name:**
Phone:	**Fax:**	**Patient Date of Birth:**
Patient's Release of Personal Health Information (PHI)		
From: Kern Psychiatric Health and Wellness Center Inc.		**To (Provider Name)**

Expiration: I understand that I may cancel this authorization at any time by sending my healthcare provider(s) my cancellation notice in writing. I understand that my healthcare provider(s) may have already released records according to this authorization, prior to receiving my written notice to cancel. Unless cancelled, this authorization expires on (date)_____.

If Member Does Not Authorize Release of PHI - *You are not required to share this information.

_____ I **do not** authorize information about my physical and/or behavioral health treatment to be released.

Member's Signature	Date of Member's Signature

Please check this box **if** the reason you are not releasing information is because you do not have a primary care provider: ☐

Information to Be Released

The only information this Coordination of Care Form authorizes for release is this one-page Notification of Treatment, including the information below. *No additional records will be released without a signed Authorization for Release.

Healthcare Coordination Information	**Medications**	**Dosages**
Treatment Start Date:		
Medication Managed by:		
ICD-10-CM:		
Treatment Plan:		

SIGNATURE: _____ DATE: _____/_____/_____

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