range Coast Psychiatric Associates

27401 Los Altos Suite 310, Mission Viejo, CA 92691

Patient's Name _____ Today's Date _____/_____/_____

Date of Birth _____/_____/_____ Age _____ □ Male □ Female SSN: _____

Address _____

City, State, Zip _____

Home Phone # _____ E-mail:_____

Cell Phone # _____ Work Phone # _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Employer/School _____ Occupation _____

Referral Source (How did you hear about us?): _____

Would you like to receive appointment reminders via text message?

- ❑ No
- ❑ Yes, I authorize OCPA to send appointment reminders via text message to the cell phone provided above

If Patient is Under 18:

Name of Parent/Guardian _____

Child Lives With _____

Emergency Contact

In case of an emergency, whom may we contact?

Name _____ Phone # _____ Relationship to patient _____

Primary Care Physician

Name _____ Date Last Seen _____/_____/_____

Phone # _____ Fax # _____

Insurance Information

Insurance Company: _____ Phone # _____

Member ID # _____ Group # _____

OCPA Intake Questionnaire

Name: _____Age: _____ DOB: _____ Sex: M F Date:_____
Insurance:_____ Referral Source: _____

GOALS

What is the main reason for which you seek treatment? _____

What would you like to achieve through treatment? _____

_____

PSYCHIATRIC HISTORY

Have you previously been treated for psychiatric conditions? Please list: _____

_____

Please list any current psychiatric medications, with dose (if known): _____

_____

Who is prescribing these medications? _____

Please list any past psychiatric medications (include how long you took them and the outcome): _____

_____

Are you currently in therapy/counseling? If so, with whom and how often? _____

Have you ever been hospitalized for a psychiatric reason, either in the ER or in an inpatient unit? _____

_____

MEDICAL HISTORY

Do you have a history of any medical conditions (include childhood problems)? _____

_____

Please list any current medications (non-psychiatric), with dose (if known): _____

_____

Have you had any surgeries? _____

When was your last physical exam/labs and what were the findings? _____

Are you allergic to any medications? _____

Currently, what is your approximate height/weight? _____ Average weight? _____

FAMILY HISTORY (for patient)

Does anyone in your family have any mental health/psychiatric problems? Whom and what issues? _____

_____

Does anyone in your family abuse drugs or alcohol? _____

Does anyone in your family have significant medical problems (e.g. heart disease, stroke, cancer, diabetes, kidney/liver problems, thyroid problems, autoimmune problems)? _____

_____

SOCIAL HISTORY

Marital/Partner Status: _____ Names/Ages of Children (if applicable): _____

_____

Are you employed? _____ What kind of work? _____

Where did you grow up? _____Highest grade/degree: _____

Where do your parents/siblings live? How is your relationship with them _____

_____

Do you have a history of abuse towards you of any kind? (If yes, explain) _____

_____

Have you had any major changes or stresses in your life recently? (If yes, explain) _____

_____

Have you been discriminated due to your age, race, gender, religion, or sexual orientation? (If yes, explain)

_____

Who is your main support? _____

SUBSTANCE HISTORY

Do you drink alcohol? If so, state your average use and type/quantity: _____

Do you smoke cigarettes or marijuana? If so, how often? _____

Do you currently use any other substances? (i.e. speed, ecstasy, cocaine, etc.)? _____

Have you used substances in the past? _____

Have you ever been in any substance abuse treatment program/rehab or any kind? _____

_____ _____

Patient Signature/Parent if minor **Date**

Orange Coast Psychiatric Associates

27401 Los Altos, Ste. 310
Mission Viejo, CA 92691
Phone: (949) 282-0027
Fax: (949) 282-0032

OFFICE POLICIES

If you have any questions or concerns, please feel free to speak with our office staff.

Initials

1. We do not call in any prescriptions refills over the telephone. Should you need a refill you must contact the office and schedule an appointment. (_____)

2. Prescriptions will be written by the doctor at the time of your appointment with an adequate amount to last you until your next appointment. (_____)

3. It is your responsibility to schedule follow up visits to receive a refill and to make sure that you have turned the hardcopy prescription into your pharmacy. (_____)

4. It is your responsibility to schedule and remember to show up to your appointment; Our reminders are only a courtesy. (_____)

5. Payments/co-payments must be made in full at the time of your visit. If you wish to be billed, we will assess a billing fee of $10. (_____)

6. The office policy for appointment cancellations / reschedules is a 24-hour (business day) notice. If a notice for a cancellation /reschedule is not received in time you will be charged $20. For example to cancel a Monday appointment you must call before 1:00 PM on Friday. **No exceptions will be made.** (_____)

7. If you fail to show up at your appointment without a notification, you will be charged a no-call, no-show (NCNS) fee of $30. **No exceptions will be made.** (_____)

8. For any paperwork completed ***within*** your scheduled session, there is no charge. For paperwork completed ***outside*** of an appointment, a fee between $25 and $50 based upon the estimated time and administrative costs, will be charged. Any paperwork estimated to exceed that amount would be discussed between the doctor and patient prior to billing. (_____)

9. A $25 fee will be charged for triplicate prescriptions written outside of an appointment. (_____)

10. There will be a $25 fee plus applicable bank charges if your check is returned. (_____)

11. The charges mentioned above will be billed directly to the patient and not the insurance company. (_____)

_____ _____ _____

Printed Name Patient/Parent Signature Date

Orange Coast Psychiatric Associates

Initial each

(_____) FINANCIAL TERMS
Upon verification of the health insurance coverage and policy limits, we will bill your insurance carrier for you (exceptions apply). You (patient or guardian) will be responsible for any applicable deductibles and co-payments/co-insurance. If you are not eligible at the time services are rendered, you are responsible for payment of the entire charge amount. Co-payments are expected to be paid at the time services are rendered. If you are without health insurance coverage, payment arrangements should be made prior to your appointment.

(_____)CANCELATIONS/MISSED APPOINTMENTS
A scheduled appointment means that the time is reserved only for you. If an appointment is missed or cancelled with less than 24-hours notice, you will be charged according to the scheduled fee. Frequent cancellations may result in the termination of your treatment; your compliance in keeping appointments and active participation in the treatment process are vital.

(_____) APPEALS AND GRIEVANCES
You have the right to request reconsideration in the case that outpatient care (number of visits) is not authorized. This is called an appeal. You can request and appeal through your provider. You risk nothing in exercising this right. You have the right to submit a complaint directly to your provider or the Clinical Group to which you belong at any time that you have a complaint about any aspect of your care. If you are not satisfied with the response you receive, you may submit the complaint to your health plan directly.

(_____) EMERGENCIES
If you are experiencing a life-threatening emergency, call 911.

(_____) TREATMENT PHILOSOPHY
During the initial evaluation period, you and your provider will clarify together the nature of the problem(s) for which you are seeking treatment, define some reasonable treatment goals, and develop a treatment plan that will help achieve those goals. Your provider can review what your health plan will cover, but ultimately you are responsible for knowing the benefits and limits of your plan. If you are confused, contact your insurance company. You are expected to be compliant with the agreed upon treatment plan between sessions, keep appointments and abstain from all mood altering substances (legal or illegal) that are not specifically prescribed for your current use. Research has shown that brief, time limited therapy focusing on specific goals results in more rapid reduction of symptoms and improvement in patient functioning. The treatment plan may include attending support groups, reading selected materials, and/or completing specific written or verbal assignments. You will participate in the ongoing review of your progress, and together with your provider, update the treatment/medication plan as appropriate.

(_____) TELEMEDICINE/EMAIL/TEXT CONSENT
I understand that telemedicine involves the communication of medical information orally, by email, or text and that there are potential risks, including the possibility, despite reasonable and appropriate efforts, that the transmission of medical information could be disrupted or distorted by technical failures in the transmission. In addition, I understand that telemedicine does not negate or minimize the risks that may be inherent in a medical illness or condition.

(_____) CONFIDENTIALITY
All information between the provider and patients is held strictly confidential unless:

1. You authorize release of information with your signature (parent/guardian <18)
2. You present a danger to others
3. You present a physical danger to self
4. Child or elder abuse is suspected

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

Orange Coast Psychiatric Associates

Authorization for Disclosure of Confidential Mental Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize:

Physician/Facility Name: _____

Phone: _____ Fax: _____ E-mail: _____

Address: _____

To release/exchange information with:

Scott D. Ispirescu, MD
27401 Los Altos, Ste. 310
Mission Viejo, CA 92691
Phone: (949) 282-0027
Fax: (949) 282-0032
Emergency/On-Call: (949) 307-0956

Purpose of Disclosure: _____

Information to be disclosed: _____

This authorization shall become effective immediately and shall remain in effect until (date) _____, except to the extent that action has been taken in reliance hereon and authorization is not earlier revoked. I understand that any requests to revise or cancel this authorization must be in writing. I hereby release OCPA, and its agents, from any and all liability arising from the release/disclosure of information as authorized.

_____ _____
Patient/Parent/Guardian/Legal Representative Date

_____ _____
Witness Date

Assignment of Benefits to OCPA

Patient Name: _____ DOB_____ ID #_____

Insurance Policy #:_____

Insured Name: _____Insured Date of Birth_____

Your relationship to the Insured: ❑ Parent ❑ Spouse ❑ other: _____

Claim #_____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Orange Coast Psychiatric Associates
27401 Los Altos, Suite 310
Mission Viejo, CA 92691
(949) 282-0027

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize OCPA to deposit checks made in my name.
- ❑ I authorize OCPA to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, if other than Policyholder

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 bind all parties whose claims may arise out of or relate to treatment or services 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. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the 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 to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

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

Article 6: **Retroactive Effect:** 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's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration 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: _____ _____
Patient's Signature Date

By: _____ _____
Patient's Representative's Signature Date

_____
Print Patient's Name

_____ _____
Print Name and Relationship to Patient

By: _____ _____
Scott D. Ispirescu, MD. Date

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.