CPS

Comprehensive Psychiatric Services

PATIENT INFORMATION		
PATIENT'S NAME:		
FOR MINORS' PARENTS/GUARDIAN NAME:		
ADDRESS (NO PO BOX PLEASE): City:	State:	Zip Code:
PHONE:	**SECOND PHONE:**	
DATE OF BIRTH:	**AGE:**	
SOCIAL SECURITY:	**GENDER:**	
BEST CONTACT INFORMATION FOR APPOINTMENT REMINDERS: EMAIL: _____ ☐ TEXT: _____ ☐ PHONE: _____ ☐		
SUBSCRIBER INFORMATION		
NAME:	RELATIONSHIP:	
ADDRESS (***If different from patient***):		
HOME/CELL PHONE:		
DATE OF BIRTH:	SOCIAL SECURITY:	
PRIMARY INSURANCE	**SECONDARY INSURANCE**	
INS CARRIER: ID NUMBER: GROUP NUMBER: AUTHORIZATION #:	INS CARRIER: ID NUMBER: GROUP NUMBER:	
ADDITIONAL PATIENT'S INFORMATION		
EMERGENCY CONTACT: Name:	Relation:	Phone:
PRIMARY CARE DOCTOR:	Phone:	
THERAPIST NAME:	Phone:	
HOW DID YOU HEARD ABOUT CPS?		

CPS

COMPREHENSIVE PSYCHIATRIC SERVICES
A Medical Group

I understand and agree to the following:

1. **AGREEMENT TO CARE**
   I request evaluation and/or treatment from a Comprehensive Psychiatric Services mental health professional. I understand that my treatment at CPS offices is voluntary and that I may discontinue treatment at any time.

2. **MISSED APPOINTMENTS AND LATE CANCELLATION CHARGES**
   I agree that **I will be billed $150** in the event that I miss an appointment or fail to cancel **24 hours** prior to the scheduled appointment. We are unable to bill your insurance carrier for missed appointments and late cancellation charges.

3. I agree to pay a **processing fee of $25.00** if my check is returned by the bank for non-payment.

4. I agree to obtain **pre-authorization** from my insurance for my treatment with my clinician.

5. I agree to pay any fees I incur for services rendered by Comprehensive Psychiatric Services, regardless of insurance coverage.

6. I agree that all doctors charge a reasonable fee to write a letter, narrative report, complete forms, etc. These fees are costs-based to include the doctor's time, labor and expertise.

Patient/Guardian's Signature: _____ Date: _____

Patient Name: _____

Consent Telemedicine/Tele-Psych

I understand that Telemedicine also known as tele-health or tele-psych. It refers to the delivery of psychiatric assessment and care via "video conferencing". In which the provider is located at a different site than the patient.

Patient/Guardian's Signature: _____ Date: _____

Patient Name: _____

CPS
Comprehensive Psychiatric Services Patient Name_____

Reason for your visit:
Current Psychiatric Medications: **Past** Psychiatric Medications:
Pharmacy of choice & address:
FAMILY HISTORY
Family History of Psychiatric Problems or Drug/Alcohol Dependency?
MEDICAL HISTORY
Medical problems and medications:
Any history of seizure?
Allergic to any medications:

PERSONAL HISTORY
Marital Status: What is your occupation?
Describe your use of alcohol and recreational drugs (including Marijuana):
FOR MINOR PATIENTS
Grade in school:
With whom do patient currently live with?

Referral Form

To: Comprehensive Psychiatric Services
Fax: (925) 944-9709

Name of Patient:_____

DOB:_____

Reason for referral:

I have evaluated the above patient in my office/facility and would like to refer to Comprehensive Psychiatric Services for evaluation and medication management

and/or _____.

Signature of Health Care Professional:_____

Name of Physician:

NPI:

Clinic/Facility:

Address:

Phone:

Fax:

CPS

COMPREHENSIVE PSYCHIATRIC SERVICES
A Medical Group

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of Use of Your Health Information for Treatment Purposes is:

- During the course of your treatment, the physician determines he/she will need to consult with another clinician. He/she will share the information and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

- We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office – we are not required to grant the request, but we will comply with any reasonable request.
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information by making a request at our office.

- Request that you be allowed to inspect and copy your health record and billing records – you may exercise this right by delivering the request to our office.
- Appeal a denial of access to your protected health information, except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
    - Is not part of the health information kept by or for the office.
    - Is not part of the information that you would be permitted to inspect and copy.
    - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made pursuant to an authorization signed by you: uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivery in a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Leela Virassammy, (925) 944-9711. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this Notice
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our Notice or by visiting our office and picking up a copy

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Leela Virassammy, Business Manager, (925) 944-9711.
Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Leela Virassammy. You may also file a complaint by mailing it to the Secretary of Health and Human Services.

We cannot, and will not require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment from the office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care about your location, and about your general condition, or your death.
- If you are seeking compensation through workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.
- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.
- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.
- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
- Other uses and disclosures, besides those identified in this notice, will be made only as otherwise required by law or with your written authorization and you may revoke this authorization as previously provided in this Notice under "Your Health Information Rights."

Effective Date: April 14, 2003

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Comprehensive Psychiatric Services
A Medical Group

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have read and/or received a copy of Provider's Notice of Privacy Practices with the effective date of April 14, 2003.

_____ _____
Signature of Patient/Patient Representative Date

_____
Relationship to Patient

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

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or call (800) 633-2322.

_____ _____

Date Patient's Name (Type or Print)

_____

Patient's Signature

_____ _____

Date Patient Representative's Name and Relationship (Type or Print)

_____

Patient's Representative's Signature

Original to be maintained in patient's medical records.

Notice to Patients about Open Payments Database

New Federal Law Requires notice to patients about open payments database.

Pursuant to Assembly Bill (AB) 1278, Comprehensive Psychiatric Services is required to provide a notice to our patients regarding the Open Payments database (Database), which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

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COMPREHENSIVE PSYCHIATRIC SERVICES
A Medical Group

3100 Oak Road, Suite 270
Walnut Creek, CA 94597
(925) 944-1733
(925) 944-9709 FAX

RELEASE OF INFORMATION

I, _____, authorize and request the following information regarding

_____, _____, to be ☐ released or ☐ exchanged.
(patient's name) (date of birth)

From:	**To:**
Clinician: _____	Name:_____
Comprehensive Psychiatric Services	Address:_____
	_____
	Phone#: _____
	Fax#:_____

From:	**To:**
Name:_____	Clinician: _____
Address:_____	Comprehensive Psychiatric Services
_____	
Phone#:_____	
Fax#:_____	

Information relevant to the following is specifically requested:

- o Evaluations
- o Psychological Testing Results
- o Medical Records
- o Other: _____
- o Treatment Plans
- o Progress Notes
- o Discharge Summaries

For date(s) of service: _____ or ☐ Any/all previous treatment dates.

This release shall be effective from _____ to _____.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Relationship to Patient