



**Diligence Behavioral and Medical
Integrated Healthcare, a Professional
Nursing Corporation (Diligence Care Plus)**

255 N. D Street, Suite 400
San Bernardino, CA 92401
Phone: 909-276-1198; Fax 909-206-0636

Credit/Debit Card Payment Consent Form

Financially Responsible Party Name: _____
First MI Last

Name on Card if different _____

I authorize Diligence Behavioral and Medical Integrated Healthcare, a Professional Nursing Corporation, dba Diligence Care Plus, to charge my card for professional services as follows:

Please Initial: _____

Any agreed-on session or service that is not paid for at the time service is rendered, unless other arrangements have been made for payment or I have a dispute concerning the service or payment for that service. No debits will be processed on my card until the dispute is resolved. I have been informed that all information provided here will never be shared with any other parties, and that it will be stored and transmitted according to strict encryption protocols and meet all federal HIPAA requirements for privacy.

Type of Card:

VISA MasterCard Discover Amex

Card Number _____ - _____ - _____ - _____

CSC/Security Code# _____

Exp. Date _____

Card Holder's Billing Address for Monthly Card Statements:

Street City State Zip

Card Holder Signature _____ Date ____ / ____ / ____

*If I have questions about these charges, I agree to first contact my provider (Diligence Care Plus). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider. Please note that to be considered a valid card an HSA card must be tied to a funded account.

FORM P-104: AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Information (Please Print)

Patient's Name: _____

Address: _____

Patient Identification Number: _____ Date of Birth: _____ (MM/DD/Year)

Group or Account # on ID card: _____

Phone number where we can reach you to process your request (required) : (_____) _____ - _____

SECTION B: Information Regarding This Authorization

I, or my authorized representative, request that health information regarding my care and treatment be used and disclose as set forth on this form. In accordance with State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG TREATMENT, MENTAL HEALTH TREATMENT**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION** and **GENETIC INFORMATION** accordance with applicable law and only if I initial the appropriate place in Section F. In the event the health information described below includes any of these types of information, and I initial the appropriate place in Section F, I specifically authorize release of such information to the person(s) indicated in Section D.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient, and this re-disclosure may no longer be protected by federal or state law. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization, unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the State Division of Human Rights. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the entity listed in Section C below. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization prior to my withdrawal.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

SECTION C: Person or Company Who Will Receive This Information

Name, relationship (if applicable), address, telephone and fax numbers of person(s) or entity/category of person to whom this information will be disclosed:

SECTION D: Purpose of This Disclosure

Reason(s) for releasing information under this authorization:

FORM P-104: AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

SECTION E: Information That Can Be Released

I authorize the following information to be used or disclosed on my behalf:

All my information. This may include health information, claims information, enrollment information or financial information, with the exception of sensitive information.

OR

Only limited information (check all that apply):

Claims Information Enrollment Information Other Information: _____

Limited to the following conditions: _____

Limited to the following dates: Start Date _____ **End Date** _____ (MM/DD/YEAR)

I also authorize the use or release of the following types of sensitive information (*please select all that apply*):

___ Mental Health Related Information ___ HIV/AIDS-Related Information

___ Alcohol/Drug Treatment Information ___ Genetic Information

Limited to the following conditions: _____

Limited to the following dates: Start Date _____ **End Date** _____ (MM/DD/YEAR)

SECTION F. Expiration of Authorization

This approval will end on the earlier of:

Date: _____ (MM/DD/YEAR)

OR

Upon termination of enrollment

SECTION G: Review and Approval

I have reviewed the contents of this form. I understand, agree and allow to use and release my information as described above.

Patient Signature

Date

X

Legal Guardian/Representative Information

Name: _____ (Print) _____ (Signature)

Relationship to Individual: _____ Date: _____

Please note: If you are a personal representative for the Patient, you must attach copies of your authorization as required by state law to represent the Patient – for example, power of attorney, health care proxy or guardianship papers.

DILIGENCE CARE PLUS CONTROLLED SUBSTANCE AGREEMENT

Responsible use

Establishing trust with my healthcare provider is of paramount importance. I recognize that the effectiveness of my medical care and medication is contingent upon a transparent and honest relationship and adherence to the terms of this agreement. This principle applies to patients of all ages; therefore, in cases where a patient is under the age of 18, a parent or guardian must also provide their signature.

Controlled substances

The prescribed medication is classified as a controlled substance and is governed by specific regulations designed to ensure safety. Any violations of these regulations may lead to the discontinuation of the medication and could also be deemed unlawful.

Agreement Importance

Failure to adhere to this agreement may result in modifications to my medication regimen, which may include dosage adjustments or a referral to a specialist. Should I have a history of noncompliance with another provider, my current healthcare provider may opt not to prescribe controlled substances.

Medication use

- I will refrain from the use of illegal drugs and will not share, sell, or trade my prescribed medications.
- I will communicate with my healthcare provider regarding all the medications I am taking, as well as any side effects I may experience.
- I will not request the same medication from multiple healthcare providers.
- I will adhere to the prescribed dosage and understand that obtaining early refills is unlikely.
- I recognize that mixing medications with other substances may pose significant risks. Therefore, I will avoid the unsafe consumption of alcohol and other drugs.

I acknowledge that if I am prescribed a benzodiazepine, it will be on a short-term basis, as Diligence Care Plus does not provide prescriptions for controlled benzodiazepine for extended periods. I will adhere strictly to the dosage guidelines established by my physician or nurse practitioner. Additionally, I understand that early refills of my medication may not be permitted. Should I fail to schedule and attend follow-up appointments with my physician or nurse practitioner, I am aware that I may be ineligible for further prescriptions.

SIDE EFFECT INFORMATION I acknowledge the role that controlled substances play in my treatment, including the various available medication alternatives and their potential side effects as prescribed by my physician or nurse practitioner. I recognize the possibility of developing a dependency on these substances, where my body and brain may come to require them for continued efficacy. I am aware that some individuals may adapt to the medication and subsequently feel the need to increase their dosage to achieve the desired effects, which may lead to addiction. I understand that discontinuation of the medication may require a gradual process, conducted under the guidance of my physician or nurse practitioner.

For women only- I acknowledge that if I choose to take this controlled medication during my pregnancy, there is a risk that my baby may be born with an addiction to it. I understand the importance of promptly informing my healthcare provider, including my doctor, nurse practitioner, or obstetrician, if I become pregnant while using this medication. It is essential to recognize that certain medications are contraindicated during pregnancy, as they may lead to birth defects or other adverse outcomes.

Refill and Safety-

I will take measures to safeguard my medication against loss or theft, and I acknowledge that replacement medications are not assured. Travel is generally not considered a valid justification for early refills. Therefore, I encourage discussion of these matters with your physician or nurse practitioner in advance.

Pharmacy and Lab Work

I will use the same pharmacy for all my prescriptions and will inform my healthcare provider if my pharmacy changes. I will adhere to all laboratory work requests, as noncompliance may have implications for my treatment plan.

Understanding Side Effects

I possess an understanding of the therapeutic benefits of the medication, its alternatives, and the potential side effects, including the risks of dependence and addiction. If necessary, I will collaborate with my healthcare provider to implement a safe tapering plan for discontinuation of the medication.

For women

In the event that I am currently pregnant or planning to conceive, I will promptly inform my healthcare provider or obstetrician, as certain medications may pose risks to the developing fetus.

Appointments

I hereby confirm my commitment to attending all recommended appointments. If my current provider departs, I will seek a new provider to evaluate my medication requirements and will schedule necessary refill appointments accordingly.

I hereby acknowledge my understanding and acceptance of these terms by affixing my signature to this agreement. Non-compliance may result in alterations to the medication or treatment plan or the termination of services.

- I am signing on behalf of the patient

Patient

Patient/Guardian signature

Provider Name /Signature



FEE AGREEMENT

We know that unexpected medical costs are one of the most common sources of stress on individuals and families. Diligence Care Plus attempts always to keep that stress to a minimum by keeping our fees as low as possible. Please read the attached fee schedule carefully. If you have any questions about the fee schedule, please ask your provider or one of the office personnel. If you are paying part or all your fees with insurance, be aware that most insurance carriers place limitations on the type of service for which they will pay. Your provider may recommend a service, or you may request a service which is not covered by insurance, in which case you will pay the entire fee. When a given service is recommended to you or if you request a service or procedure, make certain that it is clear to you whether your insurance will pay. If you are in doubt, ask our office personnel to check for you or call your insurance provider.

All fees are to be paid at the time of service for in-person visits. For Telehealth visits, all fees, coinsurances, and co-pays are paid at the time of booking. A fee of one- and one-half percent per month (18% per year) may be added monthly to all outstanding accounts more than thirty days.

Certain health insurance plans have pre-arranged contracted fee arrangements that are different than the amounts quoted. Upon verification of your eligibility and benefits, your insurance carrier will be billed for you and your provider will be paid directly by the carrier. The patient will be responsible for any applicable deductibles, coinsurance, and co-payments as described above. If you are not eligible at the time services are rendered or if your insurance carrier does not authorize the services, you are responsible for payment of the quoted fees or the rate negotiated with your insurance carrier, whichever applies.

CANCELED / MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours' notice, the patient is responsible for paying (\$100 fee if seen for psychiatric appointments), or (\$60 fee for medical appointments).

For patients who request appointments through any third-party service, such as Zocdoc, which charges Diligence Care Plus a specified fee for each patient booking, all fees collected are **NON-REFUNDABLE**, and the 24-hours cancellation window does not apply. This charge cannot be billed to your insurance plan (initial).

MEDICAL RECORDS REQUESTS

I understand I must sign a Release of Information to obtain any medical records. There is a \$35 processing fee, due at the time of request. This process will take up to 15 business days (initial)

PAPERWORK FEES

We charge a fee of eighty-five dollars (\$85) for any paperwork that we complete on your behalf and/or at your request. This includes requests to complete documents online or hard copy of documents. In general, these are documents that are not generated by Diligence Care Plus. Examples of paperwork that we charge a fee for include disability paperwork, work-required forms, school physical forms, and other documents requested by you or another entity on your behalf (initial)

There is no charge for issuing you an off-work order. This is usually a document generated by Diligence Care Plus.

DELINQUENT ACCOUNTS

If accounts become delinquent (past 30 days) our office will begin collection procedures. We will attempt to contact you directly. If your account remains delinquent (past 90 days) an outside collection agency may be used and/or small claims court action taken. In such cases, non-clinical information (as given on any intake/consent forms) may be released to assist in the collection of the amount due. Patient responsible for all court and legal fees incurred if the above action is necessary. If any of the above provisions are not satisfactory, please make alternative arrangements prior to or during your first provider appointment.

Please sign to indicate that you have carefully read and agree to the above conditions even if you missed one or more initials.

Print Client Name:

Signature of Person Financially Responsible: Date:



HIPAA and Privacy Practices Notice

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.

Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information. We must safeguard your Protected Health Information and give you this Notice about our privacy practices that explains how, when and why we may use or disclose your Protected Health Information. Except in the situations set out in the Notice, we must use or disclose only the minimum necessary Protected Health Information to carry out the use or disclosure.

We must follow the practices described in this Notice, but we can change our privacy practices and the terms of this Notice at any time.

If we revise the Notice, you may read the new version of the Notice of Privacy Practices on our website at diligenceintegratedcare.com. You also may ask for a copy of the Notice by emailing us at info@diligenceintegratedcare.com and asking us to mail you a copy or by asking for a copy at your next appointment.

Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent

We may use and disclose your Protected Health Information as follows without your permission:

For treatment purposes. We may disclose your health information to doctors, nurses and others who provide your health care. For example, your information may be shared with people performing lab work or x-rays.

To obtain payment. We may disclose your health information in order to collect payment for your health care. For instance, we may release information to your insurance company.

For health care operations. We may use or disclose your health information in order to perform business functions like employee evaluations and improving the service we provide. We may disclose your information to students training with us. We may use your information to contact you to remind you of your appointment or to call you by name in the waiting room when your doctor is ready to see you.

When required by law. We may be required to disclose your Protected Health Information to law enforcement officers, courts or government agencies. For example, we may have to report abuse, neglect or certain physical injuries.

For public health activities. We may be required to report your health information to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety.

For health oversight activities. We may be required to disclose your health information to government agencies so that they can monitor or license health care providers such as doctors and nurses.

For activities related to death. We may be required to disclose your health information to coroners, medical examiners and funeral directors so that they can carry out duties related to your death, such as determining the cause of death or preparing your body for burial. We also may disclose your information to those involved with locating, storing or transplanting donor organs or tissue.

For studies. In order to serve our patient community, we may use or disclose your health information for research studies, but only after that use is approved by Diligence Care Plus's Institutional Review Board or a special privacy board. In most cases, your information will be used for studies only with your permission.

To avert a threat to health or safety. In order to avoid a serious threat to health or safety, we may disclose health information to law enforcement officers or other persons who might prevent or lessen that threat.

For specific government functions. In certain situations, we may disclose health information of military officers and veterans, to correctional facilities, to government benefit programs, and for national security reasons.

For workers' compensation purposes. We may disclose your health information to government authorities under workers' compensation laws.

For fundraising purposes. We may use certain information (such as demographic information, dates of services, department of service, treating physicians, and outcomes) to send fundraising communications to you. However, you may opt out of receiving any such communications by contacting our Privacy Officer (listed below) and your decision to opt-out will have no impact on your treatment.

Uses and Disclosures of Your Protected Health Information That Offer You an Opportunity to Object

In the following situations, we may disclose some of your Protected Health Information if we first inform you about the disclosure and you do not object:

In patient directories. Your name, location and general health condition may be listed in our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religion may be shared with clergy.

To your family, friends or others involved in your care. We may share with these people information related to their involvement in your care or information to notify them as to your location or general condition. We may release your health information to organizations handling disaster relief efforts.

Uses and Disclosures of Your Protected Health Information That Require Your Consent

The following uses and disclosures of your Protected Health Information will be made only with your written permission, which you may withdraw at any time:

For research purposes. In order to serve our patient community, we may want to use your health information in research studies. For example, researchers may want to see whether your treatment cured your illness. In such an instance, we will ask you to complete a form allowing us to use or disclose your information for research purposes. Completion of this form is completely voluntary and will have no effect on your treatment.

For marketing purposes. Without your permission, we will not send you mail or call you on the telephone in order to urge you to use a particular product or service, unless such a mailing or call is part of your treatment. Additionally, without your permission we will not sell or otherwise disclose your Protected Health Information to any person or company seeking to market its products or services to you.

Of psychotherapy notes. Without your permission, we will not use or disclose notes in which your doctor describes or analyzes a counseling session in which you participated, unless the use or disclosure is for on-site student training, for disclosure required by a court order, or for the sole use of the doctor who took the notes.

For any other purposes not described in this Notice. Without your permission, we will not use or disclose your health information under any circumstances that are not described in this Notice.

Your Rights Regarding Your Protected Health Information

You have the following rights related to your Protected Health Information:

To inspect and request a copy of your Protected Health Information. You may look at and obtain a copy of your Protected Health Information in most cases. You may not view or copy psychotherapy notes, information collected for use in a legal or government action, and information which you cannot access by law. If we use or maintain the requested information electronically, you may request that information in electronic format.

To request that we correct your Protected Health Information. If you think that there is a mistake or a gap in our file of your health information, you may ask us in writing to correct the file. We may deny your request if we find that the file is correct and complete, not created by us, or not allowed to be disclosed. If we deny your request, we will explain our reasons for the denial and your rights to have the request and denial and your written response added to your file. If we approve your request, we will change the file, report that change to you, and tell others that need to know about the change in your file.



To request a restriction on the use or disclosure of your Protected Health Information. You may ask us to limit how we use or disclose your information, but we generally do not have to agree to your request. An exception is that we must agree to a request not to send Protected Health Information to a health plan for purposes of payment or health care operations if you have paid in full for the related product or service. If we agree to all or part of your request, we will put our agreement in writing and obey it except in emergency situations. We cannot limit uses or disclosures that are required by law.

To request confidential communication methods. You may ask that we contact you at a certain address or in a certain way. We must agree to your request as long as it is reasonably easy for us to do so.

To find out what disclosures have been made. You may get a list describing when, to whom, why, and what of your Protected Health Information has been disclosed during the past six years. We must respond to your request within sixty days of receiving it. We will only charge you for the list if you request more than one list per year. The list will not include disclosures made to you or for purposes of treatment, payment, health care operations if we do not use electronic health records, our patient directory, national security, law enforcement, and certain health oversight activities.

To receive notice if your records have been breached. Diligence Care Plus will notify you if there has been an acquisition, access, use or disclosure of your Protected Health Information in a manner not allowed under the law and which we are required by law to report to you. We will review any suspected breach to determine the appropriate response under the circumstances.

To obtain a paper copy of this Notice. Upon your request, we will give you a paper copy of this Notice.

If you have any questions about these rights, please contact us.

How to Complain about Our Privacy Practices

If you think we may have violated your privacy rights, or if you disagree with a decision we made about your Protected Health Information, you may file a complaint with our Privacy Officer by writing to info@diligenceintegratedcare.com

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to 200 Independence Avenue SW, Washington, D.C. 20201 or by calling 1-877-696-6775.

We will take no action against you if you make a complaint to either or both of these persons.

How to Receive More Information About our Privacy Practices

If you have questions about this Notice or about our privacy practices, please contact our Privacy Officer, [contact information for Privacy Officer of Covered Department].

Effective Date

This Notice is effective on February 8, 2023



We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

This signature is only acknowledgement that you have received this notice of our Privacy Practices.

Print Name:

Date:

Signature:



OFFICE POLICIES AND GENERAL INFORMATION

Office Policies and General Information Agreement to Provide Mental Services

Diligence Care Plus and its employees provide administrative support such as referral, client and insurance billing, office space, clerical services, and voice messaging to the professional staff. Diligence Care Plus employees are in the business of professional mental and medical health practice. Each physician, nurse or therapist is an independent individual performing their professional service in a private practice as governed and licensed by the State of California.

CONFIDENTIALITY

All written or spoken material from all sessions, including psychological testing, will be considered confidential unless:

1. The patient authorizes release of information with his or her signature
2. The patient presents a physical danger to self
3. The patient presents a danger to others.
4. Child/ elder abuse / neglect are suspected.

In the latter 2 cases, we are required by the law to inform potential victims and legal authorities so that protective measures can be taken.

It is understood that cases are sometimes discussed among professionals for educational, consultation and or research purposes. In addition, in couple and family therapy, or when different family members as seen individually, confidentiality and privilege do not apply between the couple or among family members.

Health Insurance: disclosure or confidential information may be required by your health insurance carrier or HMOs, PPOs, MCOs or EAPs In order to process the claims. This office or your provider has no control or knowledge over what insurance companies do with the information submitted or who has access to this information.

Litigation Limitation: due to the nature of the therapeutic process and the fact that it often involves Making a Full disclosure with regard to the matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody dispute, injuries, lawsuit, etc.), need a you (client's) nor your attorneys, Nor anyone else acting on your behalf would call on your provider or agent of this office to testify in court or at any other proceedings, nor will a disclosure of this psychotherapy or medical record be requested.

MEDIATION AND ARBITRATION

All disputes arising out of or in relation to this agreement to provide psychological or psychiatric or mental health services our medical services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. the mediator shall be a neutral third party chosen by agreement between you and your provider. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that the mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in San Bernardino County in accordance with the rules of American Arbitration Association which are in effect at the time



arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there are no agreement on a payment plan, your provider and diligence care plus can use legal means (court, collection agency, etc.) To obtain payment. The prevailing party in the arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the sum will be determined by the arbitrator.



Patient-Provider Policy Agreement

Appointment Policy

Appointments may be scheduled by phone or online. If you are unable to come to your appointment, please give at least 24 hours' notice. If you provide less than 24 hours' notice (or no notice), you will still be charged a \$100 no show/same day cancellation fee. Copayments, if any, are collected on the day of your appointment. Initial

Psychiatrist/Patient Communication

Routine telephone messages during the normal business day

When you call the office, you need to leave a message via receptionist or voicemail. We will return the call within 2 business days. If for any reason you do not receive a phone call back within 2 business days, please call back to remind us to call you. Please speak slowly and leave your full name, spelling of your last name, and phone number(s) where you can be reached. Initials

Routine Telephone Messages after hours, weekends, and holidays

During the weekend, after hours (5pm until 8:30am), and holidays, please only call if you have an urgent issue. We will do our best to return your phone call as soon as we can. Please note, also, that we will attempt to call twice, but we may or may not leave a message due to confidentiality reasons. Initials

Emergencies

If you have an emergency such as a serious side effect to a medication or suicidal/ homicidal thoughts, or other life-threatening conditions, please go to the nearest Emergency Room or call 911. Initials

Reminder Calls

Reminder calls for appointments may be placed as a courtesy. These calls are not mandatory and not receiving a reminder does not mean you no longer have an appointment. Initials

Prescriptions

Medication management takes place during your session. This includes prescribing new medication, renewals of existing prescriptions, and changes in medications and dosages. Medications are prescribed to last until your next appointment. If you miss an appointment, it is your responsibility to request a refill so that you do not run out of medication. Please notify the office 7 days prior to refilling your medication. We may not give a refill if we have not seen you recently and/or feel that an office appointment is clinically indicated. Please do not rely solely on your pharmacy to contact us.

If a Prior Authorization is needed, please allow 5 business days for Prior authorization to be processed.

It is the responsibility of the patient to follow up with the insurance for the status of any prior authorization. Initials

Termination of Provider-Patient Relationship

We reserve the right to terminate the provider-patient relationship for any reason, and in accordance with any applicable laws. Reasons why we may terminate the provider patient relationship includes, but not limited to: provider retiring/leaving or discontinuing participation with any insurance company, disruptive or violent behavior (or the patient's partner is disruptive or violent), no-shows, failure to comply with a recommended plan of care, including subsequent appointments, failure to make payment arrangements according to normal practices or as agreed, leaving the clinic/practice against medical advice, threaten lawsuits, abuse drugs or controlled substances, etc.

Before we terminate the patient-provider relationship, we may contact you directly in an attempt to resolve the issue in question. We may need to document the issue of concern and your response in your medication record for the sake of compliance and adequate record-keeping. Depending on the reason for termination, and when feasible, we may work with you to facilitate the transition of care to medical society or hospital referral center. We typically would not refer you to a specific physician.

If it ever gets to the unfortunate and regrettable stage when we need to terminate the patient-provider relationship, we will give you thirty (30) days to find a new provider or refer you to a medical society or hospital referral center. We shall provide you with a written letter by electronic communication or postal mail stating the reason for termination and the effective date. We may immediately (without 30 days' notice) terminate the patient-provider relationship verbally or in writing when there is a threat or perceived threat of violence.

Print Name:

Patient Signature:

Date:

TREATMENT CONSENT

I/we are providing consent for to receive treatment for
(medical problem) with the following treatment(s):

.....
.....

I/we understand the following:

- That I/we have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options, including
- That I/we have had the opportunity to have all questions answered to my/our satisfaction.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.
- That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

Patient signature: Date:

Parent/legal guardian: Date:

Treatment provider: Date:

* If patient is a minor, signature may be required, depending on state law.

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)		
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone		Pharmacy Address		

Patient Employer/School Information

Employer/School		Occupation	Employer/School Phone		
Employer/School Address			City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	
Insured's Address		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School		Insured's Social Security Number	
Insured's Name (as it appears on insurance card or ID)		Relation to Patient		Insured's Phone Number	

Responsible Party

Billing Name (if other than patient)		Phone	Relation to Patient		
Address		City	State	Zip	

Signature of Patient or Authorized Guardian

Date

Name: _____ Age: _____ Sex: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

Date symptoms started _____

Have you lost any days from work or school? Yes No

Medications

Have you ever taken the following medicines?

- SSRI (eg Prozac/fluoxetine, Paxil/paroxetine, Celexa/citalopram, Lexapro/escitalopram)
- Effexor/venlafaxine or Cymbalta/duloxetine
- Tricyclics (eg Elavil/amitriptyline, Pamelor/nortriptyline, Tofranil/imipramine, Anafranil/clomipramine)
- Wellbutrin/ bupropion
- Desyrel/trazodone, Serzone/nefazodone
- Mood stabilizers (eg Lithium, Tegretol/carbamazepine, Topamax/topiramate, Depakote/valproate, Lamictal/lamotrogine)
- Antipsychotic mood stabilizers (eg Seroquel/quetipine, Geodon/ziprasidone, Abilify/aripiprazole, Zyprexa/olanzapine, Haldol/haloperidol, Clozaril/clozapine, Prolixin/fluphenazine)
- Sleeping pills (eg Ambien/zolpidem, Desyrel/trazodone, Sonata/zaleplon, Restoril/temazepam)
- Anti-anxiety medicines (eg Ativan/orzepam, Klonopin/clonazepam, Xanax/alprazolam, Valium/diazepam, Buspar/buspirone)
- ADHD medicines (eg Ritalin/Concerta/methylphenidate, Adderall/amphetamine, Strattera/atomoxetine)

List other medicines you are taking:

Past Psychiatric History

Check all that apply:

- ADHD
- Anxiety
- Bipolar
- Depression
- Eating Disorder
- Phobia(s)
- Obsessive Compulsive
- Pre-Menstrual Dysphoric Disorder/PMS
- Post Traumatic Stress
- Schizophrenia
- Schizoaffective Disorder
- Substance Abuse
- Suicide Attempt

Have you seen a psychiatrist, psychologist or therapist/counselor in the past?

Yes No When? _____

Allergies

Are you allergic to any of the following?

- ACE Inhibitors
- Adhesive Tape
- Anesthetics
- Aspirin
- Barbiturates (Sleeping Pills)
- Codeine
- Iodine (including contrast dye)
- Latex
- Penicillin
- NSAIDs (Ibuprofen, Naprosyn, Advil)
- Seizure Medicines
- Sulfa

Details/Reactions: _____

Lifestyle Factors

Has anyone in your home ever physically, emotionally or sexually abused you?

Yes No

Have you ever smoked?

Yes No # of years _____ # packs/day _____

Do you smoke now?

Yes No # packs/day _____

Do you use recreational drugs? (Including abuse of prescription drugs)

Yes No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Are you currently:

- Working
- Not Working by Choice
- Unemployed
- Disabled
- Retired
- Volunteering

Have you ever served in the military?

Yes No

How would you identify your sexual orientation?

- Straight/Heterosexual
- Lesbian/Gay/Homosexual
- Bisexual
- Asexual
- Transsexual
- Other
- Unsure/Questioning
- Prefer Not to Answer

Have you ever been arrested?

Yes No

Do you have any pending legal problems?

Yes No

Do you belong to a particular religion or spiritual group?

Yes No Please list: _____

Highest Educational Level Attained:

- Grade School
- High School
- Junior College
- Undergraduate College/University
- Graduate School

Name: _____ Age: _____ Sex: _____ Date of Appointment: _____

Past Medical History

Have you ever had any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |

Hospitalizations & Surgeries

Reason: _____ Date: _____

Have you ever had an EKG?

- Yes No If yes, when? _____
Was the EKG: Normal Abnormal Not Sure

Women Only

Are you currently pregnant or think you may be pregnant?

- Yes No

Are you planning to get pregnant in the near future?

- Yes No

Birth Control Method:

- Condoms Pill Shot Patch Ring Under Skin
 IUD Tubal Ligation Vasectomy in Partner Not Applicable

Date of Last Menstrual Cycle: _____

Family History

Has anyone in your family (mother, father, siblings, grandparents) had a history of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Post Traumatic Stress |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Suicide Attempts or Thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Obsessive Compulsive Disorder | |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Phobias | |

Details: _____

Review of Systems

Psychological

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anxiety Attacks | <input type="checkbox"/> Excessive Guilt | <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Avoidance/Avoidant Personality Disorder | <input type="checkbox"/> Excessive Worry | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Increased Irritability | <input type="checkbox"/> Thoughts of harming or killing someone |
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Increased Libido | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Decrease Need For Sleep | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Increase in Risky Behavior | <input type="checkbox"/> Unable to enjoy activities |
| <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Loss of Interest in Most Things | |

General

- Chills
 Fever
 Night Sweats
 Weight Gain
 Weight Loss

Gastrointestinal

- Abdominal Cramping/Pain
 Acid Taste
 Bloating
 Diarrhea
 Frequent Belching
 Indigestion
 Nausea

Neurology

- Burning Pain
 Headache
 Seizures
 Tingling
 Tremor
 Visual Changes

Ear, Nose & Throat

- Hearing Problem
 Hoarseness
 Ringing in Ears

Cardiovascular

- Chest Pain
 Leg Swelling
 Lightheadedness
 Palpitations

Musculoskeletal

- Joint Pain
 Muscle Pain
 Weakness

Respiratory

- Chest Tightness
 Coughing
 Shortness of Breath
 Wheezing

Other: _____



SMS AND PHONE MESSAGE CONSENT

I consent to the practice (Diligence Care Plus) or its duly authorized agents, using my mobile phone number or any number that I provide them with or contacting them from to call me and/or to send SMS messages to facilitate our communication. The call or text message may come from 540-340-5070 or 909-276-1198 or 951-318-5396 or any other number regularly used for Diligence Care Plus business purposes.

Patient's Mobile number(s):

I understand and agree to all the above information.

Patient/Parent/Guardian Name:

SIGNATURE Patient (or Parent/Guardian):



Psychiatrist/Patient Policy Agreement

Appointment Policy

Appointments may be scheduled by phone or online. If you are unable to come to your appointment, please give at least 24 hours' notice. If you provide less than 24 hours' notice (or no notice), you will still be charged a \$100 no show/same day cancellation fee. Copayments, if any, are collected on the day of your appointment. Initial

Psychiatrist/Patient Communication

Routine telephone messages during the normal business day

When you call the office, you need to leave a message via receptionist or voicemail. We will return the call within 2 business days. If for any reason you do not receive a phone call back within 2 business days, please call back to remind us to call you. Please speak slowly and leave your full name, spelling of your last name, and phone number(s) where you can be reached. Initials

Routine Telephone Messages after hours, weekends, and holidays

During weekend, after hours (5pm until 8:30am), and holidays, please only call if you have an urgent issue. We will do our best to return your phone call as soon as we can. Please note, also, that we will attempt to call twice, but we may or may not leave a message due to confidentiality reasons. Initials

Emergencies

If you have an emergency such as a serious side effect to a medication or suicidal/ homicidal thoughts, or other life-threatening conditions, please go to the nearest Emergency Room or call 911. Initials

Reminder Calls

Reminder calls for appointments may be placed as a courtesy. These calls are not mandatory and not receiving a reminder does not mean you no longer have an appointment. Initials

Prescriptions

Medication management takes place during your session. This includes prescribing new medication, renewals of existing prescriptions, and changes in medications and dosages. Medications are prescribed to last until your next appointment. If you miss an appointment, it is your responsibility to request a refill so that you do not run out of medication. Please notify the office 7 days prior to refilling your medication. We may not give a refill if we have not seen you recently and/or feel that an office appointment is clinically indicated. Please do not rely solely on your pharmacy to contact us.

If a Prior Authorization is needed, please allow 5 business days for Prior authorization to be processed.

It is the responsibility of the patient to follow up with the insurance for the status of any prior authorization. Initials

Print Name:

Patient Signature:

Date:

Personal Representative Request Form

This form identifies a person who has legal authority to act on a member's behalf in making decisions related to the member's health care. This provision applies to persons with legal guardianship, power of attorney, or other documented legal authority to act on behalf of a member. **Questions regarding this form should be directed to the Member Services Department at the number located on the back of the member's identification (ID) card.**

Member Information: (Include any letters in front of the identification number on the member ID card.)

Name: (First, Middle, Last, Title)		Member ID Number:
Address: (including zip code)		Date of Birth: (Month/Day/Year)
Home Telephone Number: (including area code)	Daytime Telephone Number: (including area code)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Health Plan: (The Health Plan is your insurance carrier or HMO. Please enter the Health Plan name as it appears on the member's ID card.)

Personal Representative Information:

Name: (First, Middle, Last, Title)	Personal Rep. Mother's Maiden Name: (will be used for identity verification)
Address: (including zip code)	Telephone Number: (including area code)

A copy of a Power of Attorney or other legal document must be attached to this form in order for it to be processed. Attach supporting documentation and describe (for example: Power of Attorney for health care decisions, Custodial Order, Executor of Estate).

Type of Documentation:

Signature/Date: (The member's legal Personal Representative must sign and date this form for it to be processed.)

Print Name: _____

Personal Representative Signature: _____

Date: _____

Important Information about Personal Representatives

- The federal Privacy Rule requires your Health Plan to follow certain procedures before it may provide access to your Protected Health Information (PHI) to someone other than you. PHI is information about you that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, and the provision of health care to you or the payments for that care.
- Your Health Plan will release PHI to your Personal Representative upon receipt of documentation supporting their legal authority to make health-related decisions on your behalf (for example: a valid Power of Attorney, guardianship or other legal document).
- Your Health Plan will also recognize as a Personal Representative an executor, administrator, or a person recognized by law as having authority to act on behalf of a deceased member or the member's estate.
- Your Health Plan will not however, treat someone as your Personal Representative if we reasonably believe: (1) you may be subject to domestic violence, abuse or neglect by the Personal Representative; (2) treating the person as your Personal Representative could endanger you; or (3) in the exercise of professional judgment (for example, in a licensed professional's judgement), your Health Plan decides that it is not in your best interest to treat the person as your Personal Representative.
- A Personal Representative designation will remain in effect until the member, a court order, or an applicable law revokes it.
- To assist your Health Plan in responding to this request, please complete this form by printing or typing into the spaces provided. Attach additional pages if necessary to clarify your request. Attach a copy of the document supporting your Personal Representative's legal authority to act on your behalf.
- Mail or fax the completed form and supporting documentation to:

Member Correspondence
P.O. Box 41890
Philadelphia, PA 19101-1890
Fax Number: 215-241-2042 or 1-888-457-3013 (Toll Free)

- If you have any questions about his form, please call the Member Services Department at the number on the back of your member identification card.