SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

PATIENT INFORMATION SHEET (PLEASE PRINT)

PATIENT NAME LAST _____ FIRST _____ MI _____

DOB _____ SEX ❑ M ❑ F LANGUAGE _____ Education _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

CELL _____ EMAIL _____

Consent - I consent use of ❑ SMS and Secure-Email for notification such as appointment reminders. I also understand that my mobile service provider may charge for each message I receive and that it is my responsibility for all such charges. I understand that text and email messages are not for emergency use and text messages are neither secure nor HIPAA compliant. **Initial** _____

MARITAL STATUS ❑ Unmarried ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other _____

PROFESSION ❑ Student ❑ Employed ❑ Unemployed ❑ Housewife ❑ Retired ❑ Other_____

RACE✍ ❑ White ❑ Black ❑ Asian ❑ Pacific Islander ❑ Multi ❑ Declined ❑ Other _____

ETHNICITY✍ ❑ Hispanic/Latino ❑ Declined ❑ Other _____

REFERRAL NAME _____

FOR MINOR ❑ PARENT / ❑ GUARDIAN NAME _____

DOB_____ Patient Relationship _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE NAME_____ ID _____

SUBSCRIBER RELATION ❑ Self ❑ Spouse ❑ Child ❑ Other _____ D.O.B._____

GROUP# _____SSN _____ EMPLOYER NAME _____

SECONDARY INSURANCE INFORMATION ❑ NONE Initial: _____

SECONDARY INSURANCE NAME_____ ID _____

SUBSCRIBER RELATION ❑ Self ❑ Spouse ❑ Child ❑ Other _____ D.O.B._____

GROUP# _____SSN _____ EMPLOYER NAME _____

EMERGENCY CONTACT

NAME _____PHONE# _____

ADDRESS: _____

Signature of Patient / Legal Guardian* _____ Date _____

Name (Printed) _____ Relationship to Patient _____

Patient Name (if different from that above) _____

*Except for birth parents, proof of legal guardianship that includes right to make medical treatment decisions for the patient above must be provided along with personal identification

Documentation Required for Patient File: ❑ Copy of Insurance Card both front and back

❑ Identification (parent/legal guardian's in case of Minor)

ITEMS MARKED ✍ ARE OPTIONAL

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

FINANCIAL POLICY

Please understand that payment of your bill is considered a part of your treatment. SCPG, Inc will bill your insurance; however, you are responsible for all co-payment and deductibles as set by your insurance plan and to obtain and track authorizations for your treatment. Co-payment amounts may vary during the course of treatment, as outlined by your plan. Co-payments and any deductible identified are due and payable at each appointment.

If at any time during your treatment you become ineligible for coverage by your insurance, you will be responsible for 100% of your bill. For special modalities of treatment not covered by your benefit plan, a written agreement will be signed between you and your clinician. This agreement should cover the fees and treatment plan and should never contain fees more than the fee-for-service discount rates that your benefit plan provides.

You are responsible to notify any changes to your insurance, contact information such as address, phone, and email well in advance. On the day of your appointment, if you are found to be ineligible, you are responsible to pay office fee for all services.

Minor Patients

The parent or the legal guardian making appointments and accompanying a minor are responsible for full payment of the visit charges. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved payment plan or payment by cash or check at time of service has been verified.

Courtesy Reminder Calls / Messages

I understand that my doctor's office will do the appointment reminders and SMS messages as a courtesy only and that keeping track of my appointments and keeping my appointment is my responsibility. **Initial: _____**

No-Show or Missed Appointments Fee / Discharge Policy

Appointments not kept (missed) and those not canceled or rescheduled at least 24 hours in advance are marked as No Show. For all No Show appointments, a $65.00 fee is charged to patient. This fee is not payable by your insurance and is imposed to recoup lost income. If you miss or No Show for two appointments, all future appointments will be cancelled. If you miss or No Show three times, in one year, you will be discharged from our office, and you may need to seek help outside of our practice. **Initial: _____**

Miscellaneous Fees

Please note that outside forms completion is at your doctor's discretion and not a guarantee. There will be a charge for all paperwork completed by my provider. I understand that the following services have a fee not covered by my health plan and are my sole responsibility. **Initial: _____**

- $10.00 per page for all forms requiring completion
- $25.00 for all disability paperwork
- $65.00 Cancellation within 24 hours of appointment time/ no show fee
- $30.00 Medical Records
- $50.00 Letter writing
- $500.00 Court Appearances – this fee applies for each time, even if the scheduled session is postponed and must be paid in advance before we can block your provider schedule for the purpose

Updates to Patient Contact Information and Insurance Coverage

I agree that I will bring my identification and insurance card every time I come for my appointment. I understand that it is my responsibility to inform my doctor's office any changes to insurance coverage, mailing address and phone number on file. I understand that my insurance verification and authorizations are obtained by my doctor's office as a courtesy. If my plan is not active or if my plan does not cover the services provided, my appointment could be cancelled without warning, or I could be charged full fee for the services. So, it is important that I must keep my contact information updated all time and provide timely information.

I understand and accept responsibility to pay the full fees for all services rendered by my doctor such as copay, coinsurance and/or deductible assigned by my plan or if my insurance on file determines that there is no coverage or changes the coverage after the service is rendered. Please sign below indicating your understanding of SCPG Inc's financial policy.

Signature of Patient, Legal Guardian/Legal Representative: _____ Date: _____

Name (Printed): _____ Relationship to Patient: _____

Patient Name (if different from that above): _____

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

Consumer Notice of Rights and Responsibilities

Dignity and Respect

- You have the right to be treated with consideration, dignity and respect – and the responsibility – to respect the rights, property and environment of all physicians and other health care professionals, employees and other patients.
- You have the right to access your own treatment records and have the privacy and the confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status or culture; or economic, educational or religious background.

Knowledge and Information

- You have the right to receive information about the organization's services and practitioners, clinical guidelines, and member's right and responsibilities.
- You have the right – and the responsibility – to know about and understand your health care and your coverage, including:
  - Participating with your physician and other healthcare professionals in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
  - The names and titles of all health care professionals involved in your treatment.
  - Your clinical condition and health status.
  - Any services and procedures involved in your recommended course of treatment.
  - Any continuing health care requirements following your discharge from a provider's office, hospital, or treatment program.
  - How your health plan operates – as stated in your Policy and/or Certificate.
  - The medications prescribed for you – what they are for, how to take them properly and possible side effects.

Continuous Improvement

- As a partner with your health plan and any health care professional who may be involved in your care, you have the right to:
  - Contact a Member Service Associate to address all questions and concerns as well as to make suggestions for improvement to the health plan and/or the members' rights and responsibilities policies.
  - Ask questions about any clinical advice or prescribed treatment if you need an explanation or want more information.
  - Appeal any unfavorable behavioral health care decisions by following the established appeal or grievance procedures of your health plan.

Eligible Employee
Accountability/Autonomy

- As a partner in your own health care, you have the right to refuse treatment – providing you accept responsibility and the consequences of such a decision—and the right to refuse to participate in any medical research projects.
- You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals.
- You also have the responsibility to:
  - If you have Kaiser or United Health Care Insurance identify yourself as such when receiving behavioral health services.
  - Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved during the course of your treatment.
  - Be on time for all appointments. Notify your provider's office in advance if your need to cancel or reschedule appointment.
  - Receive all non-emergent or urgent care through your assigned behavioral health provider and obtain preauthorization of service from Managed Care Company, if applicable.
  - Notify your behavioral health plan within 48 hours – or as soon as possible—if you are hospitalized or receive emergency care.
  - Pay all required co-payments and deductibles at the time you receive behavioral health care services.
- You have the right at all times to contact a member service associate for assistance with issues regarding your behavioral health plan.
- It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care.

If you have any questions or complaints regarding your rights, contact our management (ask for Grievance Form or send email to experience@socalpsych.com) or the Member Service Associated with your Insurance Company.

Patient or Guardian's Signature _____ Date _____

Therapist Signature _____ Date _____

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

Mental Health Disclosure Form

Treatment Philosophy-Explanation of Brief Therapy

- Brief therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask. **Initial here: _____**

Limits of Confidentiality Statement

- All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:
  1. The patient authorizes a release of information with a signature.
  2. The patient's mental condition becomes an issue in a lawsuit.
  3. The patient presents as a physical danger to self (*Johnson v County of Los Angeles, 1983*).
  4. The patient presents as a danger to others (*Tarasoff v Regents of University of California, 1967*).
  5. Child or Elder abuse and/or neglect are suspected (*Welfare & Institution and/or Penal Code*).

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

- All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion is not to be discussed outside of the counseling sessions. **Initial here: _____**

Release of Information

- Release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation, and professional communication require prior consents. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. **Initial here: _____**

Emergency Access

- We cannot take your calls during the afterhours. You can leave voice mail which is reviewed and responded to during the following business day. For all emergencies, you must call 911 or go to the nearest emergency for help. **Initial here: _____**

Medication Refills

- You are recommended to make follow up appointment well in advance before your run out of your medication. Our doctors do not approve refills. Same day (walk-in) appointments are not possible unless there is opening. **Initial here: _____**

Consent for Treatment

- I authorize and request my practitioner carry out psychological exams, treatment and /or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me..
  Initial here: _____

_____ _____
Patient/Guardian Signature **Date**

_____ _____
Practitioner Signature **Date**

General Consent for Child or Dependent Treatment

- I am the legal guardian or legal representative of the patient and on the patient's, behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ _____
Patient Name Patient Social Security Number

_____ _____
Signature of Legal Guardian/Legal Representative Date

_____ _____
Relationship to Patient Benefit Plan Subscriber Name

_____
Mental Health Benefit Plan

_____ _____
Practitioner Date

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

ASSIGNMENT OF BENEFITS – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to the Southern California Psychiatric Group, Inc / Provider of service for mental health benefits, if any, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services.

Signature of Patient/Legal Representative: _____

Name (Printed): _____ Relationship to Patient: _____

Patient Name (if different from that above): _____

Date: _____

PATIENT ACKNOWLEDGEMENT of NOTICE OF PRIVACY PRACTICES

I, _____ have received the Notice of Privacy Practices, and
Patient Name (Please Print)
understand that Southern California Psychiatric Group, Inc. has certain legal duties to safeguard my Protected Health Information. (PHI). I also understand that I have certain rights in regard to my (PHI).

_____ _____

Signature of Pt / Legal Guardian **Date**

APPEALS AND GRIEVANCES

I understand that any questions or complaints I can contact management and file grievance either through form provided in office or send direct email to **experience@socalpsych.com**. Alternatively, I understand that I can contact my Member Services using the number listed on the back of my insurance card. I understand that I can also file a complaint with California Department of Consumer Affairs either by phone 800-952-5210 or online at www.dca.ca.gov

_____ _____

Signature of Pt / Legal Guardian Date

AFTER HOUR CALLS POLICY

It is important to understand that we are not an acute care and/or emergency facility. This is an outpatient clinic with limited business hours. All calls during the non-business hours and on weekends will be forwarded to the appropriate office to be reviewed the following business day and responded to as needed.

For all emergencies, you must call 911 or go to the nearest emergency room.

_____ _____

Signature of Pt / Legal Guardian **Date**

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

HEALTH CARE COORDINATION FORM

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

PATIENT NAME: _____ DOB: _____

MEMBER ID NUMBER OR SOCIAL SECURITY NUMBER: _____

I hereby authorize the release of the medical information listed below which pertains to my medical history, test results, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and /or substance abuse diagnosis and treatment to my primary care physician:

Primary Care Physician Name: _____ ❑ Decline ❑ Do not have a PCP

Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care, which I may receive from specialists. I further understand that I have a right to receive a copy of this authorization upon my request. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to this recipient only with signed consent from me.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

SYMPTOMS IDENTIFICATION and HEALTH HISTORY

PATIENT'S NAME _____ **DOB** _____

Please state your presenting problem(s) and the length of time you have experienced them: _____

_____

_____

Please take a few minutes to complete the following. Check the number that applies to you.
The numbers range from 0 meaning not present through 4 meaning severe problem

SYMPTOM	← *NONE*		–		*SEVERE* →
Crying spells	0	1	2	3	4
Extreme tiredness	0	1	2	3	4
Feelings of dread	0	1	2	3	4
Feelings of hopeless / helpless	0	1	2	3	4
Headaches	0	1	2	3	4
Hearing voices	0	1	2	3	4
Impulse control problems	0	1	2	3	4
Loss of appetite	0	1	2	3	4
Loss of interest in activities	0	1	2	3	4
Loss of interest in sex	0	1	2	3	4
Nervousness	0	1	2	3	4
Feeling helpless / hopeless	0	1	2	3	4

SYMPTOM	← *NONE*		–		*SEVERE* →
Nightmares	0	1	2	3	4
Panic attacks	0	1	2	3	4
Poor concentration	0	1	2	3	4
Poor memory	0	1	2	3	4
Sadness	0	1	2	3	4
Sleep Problems	0	1	2	3	4
Suicidal thoughts & plans	0	1	2	3	4
Suspiciousness	0	1	2	3	4
Weight loss	0	1	2	3	4
Worry all the time	0	1	2	3	4
Others (Please write)	0	1	2	3	4
	0	1	2	3	4

ALLERGIES? ☐ YES ☐ NO If Yes, list_____, _____, _____

HEALTH HISTORY ☐ BP ☐ DIABETIC ☐ ASTHMA ☐ CORONARY ☐ SURGICAL ☐ _____

PAST PSYCH HISTORY ☐ YES ☐ NO _____ **HOSPITALIZATIONS ☐ YES ☐ NO** ____ **TIMES**

FAMILY PSYCH HISTORY ☐ YES ☐ NO IF YES WHO _____**WHAT**_____

ARE YOU TAKNG ANY MEDS? ☐ YES ☐ NO PRESCRIBER _____

_____ **HEIGHT** _____**FT** _____**IN WEIGHT** _____**LBS**

DO YOU USE ANY OF THE FOLLOWING? ANSWER SPECIFICS FREQUENCY, QUANTITY, FORM OF USE, START AGE / FOR HOW LONG, IF SOBER FOR HOW LONG AND RELAPSE REASONS IF ANY, ETC.

CAFFINE ☐ YES ☐ NO _____

SMOKE ☐ YES ☐ NO ☐ NEVER ☐ PASSIVE_____

TOBACCO ☐ YES ☐ NO ☐ NEVER_____

ALCOHOL ☐ YES ☐ NO ☐ NEVER _____

DRUGS ☐ YES ☐ NO ☐ NEVER _____

FAMILY HISTORY: DRUGS ☐ YES ☐ NO WHO _____ **ALCOHOL ☐ YES ☐ NO WHO** _____

PHARMACY NAME _____ **PHONE** _____

CROSS STREETS/ADDRESS_____ **CITY**_____

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

CHILDHOOD PROBLEMS ☐ **DEVELOPMENTAL** ☐ **ACADEMIC** ☐ **BEHAVIORAL WITH** ☐ **PEERS** ☐ **TEACHERS**

EXPLAIN _____

_____

_____

FAMILY SUPPORT ☐ **BILOGICAL PARENTS** ☐ **SEPARATED** ☐ **TOGETHER** ☐ **DECEASED**

DESCRIBE RELATIONSHIP GROWING UP WITH YOUR MOTHER _____

_____ WITH YOUR FATHER _____

IMMEDIATE FAMILY LIVING WITH YOU ☐ **FATHER** ☐ **MOTHER** ☐ **BROTHER(S) _____** ☐ **SISTER(S) _____**

☐ **GRAND PARENT(S)** ☐ **STEP FATHER** ☐ **STEP MOTHER** ☐ **SPOUSE** ☐ **CHILDREN _____**

_____

DESCRIBE ANY FAMILY PROBLEM WHILE GROWING UP RELATING TO

ALCOHOL / DRUG ABUSE _____

SEXUAL / EMOTIONAL /PHYSICAL ABUSE _____

_____

DESCRIBE CURRENT PROBLEMS IF ANY _____

_____

_____

CURRENT WORK ENVIRONMNET _____

LSIT ANY CURRENT PROBLEMS: SOCIAL, OCCUPATIONAL ☐ ISOLATION FROM FAMILY / FRIENDS / CHILDREN ☐ COMPLETING DAILY TASKS ☐ PROBLEMS WITH SUPERVISOR ☐ SEVERE FINANCIAL STRAIN ☐ DIVORCE
OTHER PROBLEMS: ☐ OTHERS TRYING TO CONTROL ME OR MY THOUGHTS ☐ INVISIBLE FORCES CONTROLLING MY THOUGHTS ☐ HEARING VOICES ☐ REPETITION OF THROUGHTS OVER AND OVER ☐ FEELING THAT SOMEONE IS TRYING TO HURT OR DO SOMETHING AGAINEST ME ☐ UNABLE TO CONTROL MY BEHAVIOUR

_____

_____

_____

_____

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SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC
CONTROLLED SUBSTANCE CONTRACT

Patient Name _____ Date of Birth _____

Your physician is committed to treat your condition. Some medications are regulated with strict guidelines by State and Federal Agencies or by both. This agreement is a tool to establish a clear understanding of the situation for both your and the physician, within the law, for proper controlled substance use.

1. I understand that most controlled substances have a potential for dependency and abuse.
2. I understand that Narcotics are not psychiatric medications and SCPG doctor cannot prescribe them.
3. You must disclose all medication you receive (including all benzodiazepines or stimulants) from any external physician to your SCPG physician during every visit. You must not receive benzodiazepines or stimulants from any outside physician except when your SCPG doctor is out on vacation.
4. I understand that all my medication orders will be sent electronically and to only one pharmacy. Should there be need to change pharmacy, I will inform your office well in advance. Once the prescription is sent, I understand that my doctor's office can't resend the medication to different pharmacy.
5. The prescribing physician has your permission to discuss all diagnostic and treatment details with the dispensing pharmacists and/or other healthcare professionals who provide you care for the purpose of maintaining accountability.
6. I agree to keep all your medication safe, secure, and out of reach from children. If the medication is lost, stolen, gets wet, destroyed, left on airplane, etc., I understand that it will not be replaced until the next prescribing date or it may not be replaced at all.
7. I will not share, sell or otherwise permit others including spouse or family members to have access to these medications.
8. I agree to not consume excessive amount of alcohol in conjunction with prescribed controlled substances. I agree to not purchase, obtain, or use any illegal drugs. It is not recommended to mix benzodiazepines and opioid medication as it could lead to adverse outcomes.
9. During my treatment, I understand that unannounced urine drug screening could be requested and that I must comply with such requests. Any missed tests will be considered positive for drugs. Presence of unauthorized substances may result in termination of my treatment by my physician at SCPG.
10. I understand and consent that my insurance, all my physician(s) and State and Federal authorities including my pharmacist(s) could review history of my controlled substance prescription records from time to time.
11. I understand that early refills or renewals will not be approved. I must remember to make and keep my appointments as recommended before I run out of my medication. No phone refills will be provided for any controlled substances.
12. I understand that failure to adhere the above requirements may result in cessation of my therapy with controlled substances prescribed by my doctor.

You affirm that you full right and power to sign and bound by this agreement, and that you have read, understood and accept all its terms.

Patient / Guardian Signature: _____ Date: _____

Name Signed (if applicable Guardian Name) _____

Physician Signature: _____ Date: _____

INFORMED MEDICATION CONSENT

Patient Name _____ Date of Birth _____

I am a patient of ____**Dr B Nallamothu, MD**_____

She recommended me the following medications for treatment of my disorder after evaluation. Although everyone's response to this medication is different, in many cases like mine, this medication has demonstrated that it is helpful in alleviating or reducing some of the signs and symptoms typical of my disorder. While there is no guarantee that this medication will be 100% effective, my provider is of the opinion that there is no suitable alternative treatment for me, at this time, which is likely to be more effective.

I hereby acknowledge that my provider did discuss with me the various risks and benefits associated with taking the psychotropic medication, checked below.

- ☐ **Neuroleptic** **Name(s) _____**

  Dry mouth, constipation, blurred vision (close-up), and various rashes, blood pressure changes (drop in blood pressure with change of position), and muscle spasms. Tardive dyskinesia—a side effect that may or may not develop with taking neuroleptics, commonly after years of therapy, was discussed. Tardive dyskinesia is a condition that may occur while taking

the medication or after the medication has been discontinued; and it consists of movement of certain muscles of the trunk (pelvis and hips).

- ☐ **Anti-Depressant (SSRI)** **Name(s) _____**
  Nausea, sleepiness, loss of strength, dizziness, insomnia, sweating, and ejaculatory delay.
- ☐ **Anti-Depressant (Tricyclic)** **Name(s) _____**
  Dry mouth, sedation, blurred vision, blood pressure changes, constipation, ECC changes, changes in heart beat, urinary retention, allergic reaction.
- ☐ **Anti-Depressant (MAOI)** **Name(s) _____**
  Must adhere to a special diet and use special caution in taking other medication which can raise the blood pressure when combined with this medication for approximately two weeks after discontinuation, dry mouth, restlessness, allergic reaction.
- ☐ **Lithium Carbonate** **Name(s) _____**
  At therapeutic levels these side effects maybe seen: tremors, nausea, vomiting, diarrhea, frequent urination, fatigue, thyroid changes, and allergic reactions. At higher levels these side effects may be seen: confusion, seizures, coma.
- ☐ **Mood Stabilizer** **Name(s) _____**
- ☐ **Anxiolytics and Sedatives** **Name(s) _____**
  Sedation, slowed reaction time, psychological and physical dependence and allergic reaction.
- ☐ **Stimulant** **Name(s) _____**
  Nervousness, insomnia, decreased appetite and weight loss, rapid heart beat, increased blood pressure, psychological and physical dependence.
- ☐ **Other** **Name(s) _____**

Any of these medications may cause drowsiness and might increase the effects of alcohol or other sedatives (such as drowsiness or poor coordination). Caution in driving and operating machinery and other tasks requiring alertness and coordination should be exercised. This explanation of risks and benefits is not meant to be all-inclusive. There are other potential adverse reactions. I should promptly notify my provider and or another member of the staff if there are any unexpected changes in my condition.

I understand that I may not be compelled to take this medication and that I may decide to stop taking it at any time. I understand that the symptoms of my disorder may return or worsen if I stop taking this medication.

I understand that taking psychotropic medication during pregnancy may cause increased risk to the fetus and that I take the responsibility of informing my provider of any possibility of my being pregnant.

After a period with a specific medication, my provider may determine that a different dosage of the same medication or a different type of medication may be necessary before the best medication is found.

I also understand that although my provider believes that this medication will help me, there is no guarantee as to the results that may be obtained. On this basis, I authorize my provider (or anyone authorized by him or her) to administer such doses of medication at such intervals as my provider believes is best. I also authorize my provider (or anyone authorized by him or her) to change the type of medication I am to receive or the doses of my medication in order to achieve the best results possible.

Patient / Guardian Signature: _____ Date: _____

Patient Name _____Guardian Name (if applicable) _____

Provider Certification:
I the undersigned provider, hereby certify that I have discussed with the patient or the patient's legal representative the information described in this document. I further certify that the patient was encouraged to ask questions and that all questions were answered.

_____

B NALLAMOTHU, M.D.
Diplomate, The American Board of Psychiatry and Neurology
Subspeciality in Child and Adolescent Psychiatry
CA License A89852

SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC
EMEDICINE / TELEPSYCHIATRY / TELE-MENTAL HEALTH SERVICE
WHAT IS TELEMEDICINE AND TELEPSYCHIATRY OR TELE-MENTAL HEALTH SERVICE?

PATIENT NAME: _____ DOB: _____

CURRENT PATIENT LOCATION: _____, CA

Telemedicine (also sometimes called telehealth / telepsychiatry / tele-mental health) services is a way to deliver healthcare services locally to a patient when the healthcare provider or the patient is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self-management and caregiver support of the patient. Telemedicine services often provides a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to- computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

I read and understand the information provided in this document. I discussed any question I had with Dr._____ and all my questions were answered to my satisfaction.

Date _____ Patient's or Guardian Signature _____

Name and Relationship to Patient if Guardian _____

CONSENT TO USE TELEMEDICINE

PATIENT NAME: _____ DATE OF BIRTH: _____

CURRENT PATIENT LOCATION: _____, CALIFORNIA

I, _____, am physically located in _____, CA. At the beginning of each telemedicine session, I will help Dr._____ to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. Telemedicine and Tele-Mental Health Session are interchangeable in this agreement since this document applies to both Psychiatrist and Therapists sessions.
2. Dr._____ is located in and licensed by the State of California. Dr._____ may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact Dr._____. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273- TALK (8255) for free 24-hour hotline support.
3. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by Dr._____ will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

4. Dr._____ believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.
5. If Dr._____ believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, Dr._____ may discontinue telemedicine services and schedule an in-person consultation with Dr._____ or refer me to a healthcare provider in my area who can provide such services.
6. I have the right to withdraw consent to the use of telemedicine services at any time and receive in- person healthcare services with Dr._____.
7. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with Dr._____ and understand there are limitations to the technology which may require an in-person consultation.
8. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with enough lighting and privacy that is free from distractions or intrusions during my telemedicine communications.
9. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by Dr._____ to me will be encrypted during transmission and will be stored only by Dr._____. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.
10. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto- remember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to Dr._____ and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.
11. I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record. Or No part of the encounter will be recorded without my written consent.
12. I agree that I will not record the telemedicine session content in any manner including audio and video, electronic and in any form.
13. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.
14. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any question I had with Dr._____ and all of my questions were answered to my satisfaction.

Date:_____ Patient or Guardian's Signature: _____