

**PATIENT INFORMATION**

Patients Name..... D.O.B.....  
 Age..... Sex..... Marital Status.....  
 Address..... Social security.....  
 City..... State..... Zip Code.....  
 Home Phone..... Cell Phone.....  
 Employer..... Occupation.....  
 Employer Address.....  
 City..... State..... Zip Code.....  
 Work Phone..... May We Contact You at Work.....  
 Referred By .....  
 Family Physician PCP.....Phone# .....  
 In Case of Emergency, Notify.....Phone#.....

**RESPONSIBLE PARTY INFORMATION**

(SKIP IF SAME AS ABOVE)

Responsible Party Name..... D.O.B. ....  
 Relationship to Party.....Social Security.....  
 Address: Street.....City.....  
 State..... Zip Code.....  
 Home Phone..... Cell Phone.....

**FINANCIAL TERMS: INSURANCE COVERAGE CO-PAYMENT**

You are responsible for obtaining prior authorization for treatment from your insurance company, However, You are responsible for co-pay amounts and deductibles as set by your benefit plan. Co-pays are due and payable at the time of your appointment before seeing the Provider.

Thereby irrevocably assigned to Pacific Neuropsychiatric Specialists and/ or (Dr. Gus Alva, Dr. Kellogg, Dr. Alex Alva, Dr. Mann) all payments for medical services rendered and all mayor medical benefits. I fully understand that I am financially responsible for any charges not covered by an authorization. If at any time during me treatment I become aware that I am ineligible for insurance coverage, I understand I will be financially responsible for 100% of the outstanding bill. I also undertake to inform Pacific Neuropsychiatric Specialists at the earliest of any changes in my personal and or insurance information.

INITIALS.....

**CANCELLATIONS AND MISSED APPOINTMENTS**

Scheduled appointment times are reserved specially for you. If an appointment is missed or is cancelled with less than 24- Hour workday notice, you will be directly billed according to the applicable fee. Missed appointments are not covered by your insurance and charges associated with them are your responsibility. Repeated "NO SHOW" appointments without sufficient and valid cause will lead to discontinuation of service.

I understand that I will be charged up to \$25 (twenty five) for failed follow-up sessions and that this agreement will remain in effect for the entire duration of my treatment

INITIALS.....

**ADDITIONAL AND/OR UNCOVERED SERVICES**

I understand that I will be charged at the regular hourly rate of \$350 (three hundred and fifty) for services required outside of the treatment session. These will include consultations with other professionals. I will be charged a fee of \$150 (one hundred and fifty) for follow up appointments. I will be charged a fee of \$25 for any disability forms conservatorship petitions, or any letter that is required for a medical leave etc. from work, school or other related areas.

I have read and agree to the above commitments.

Signature.....

Date.....

### OFFICE POLICY

#### Information about your appointment

Initial evaluations/assessments and full sessions are generally about 30 to 45 minutes in duration. Subsequent follow-up sessions range from 15 to 30 minutes in duration. Medication management sessions are about 15 minutes in duration. Based on a case to case basis. However, these sessions might require more time than expected. All paperwork and submission o co-pay has to be completed before the beginning of the session. Please arrive and report accordingly for ease of operation. Please respect time guidelines so next patient waiting is not affected.

#### Confidentiality

All information whatsoever exchanged between the provider and the patient is held strictly confidential per the Federal HIPPA Act in effect. Legal exceptions as follow exist:

1. The patient authorizes a "release of information" with signature on applicable format.
2. The patients' mental health and status become an issue in a lawsuit.
3. The patient presents and poses a physical danger to self and/or others.
4. child or elder abuse and/or neglect are suspected (Welfare Institution and/or penal Codes)

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

#### Release of Information

I authorize release of information to my family physician/primary care physician, other health care providers, institutions and federal sources for the purpose of diagnosis, treatment, consultation and professional community. I further authorize release of information for claims, certifications, case management, benefits administration and other purposes related to my health plan.

Signature.....

Date.....



**Pacific  
Neuropsychiatric  
Specialists**

3151 Airway Avenue, Suite T-3  
Costa Mesa, CA 92626

Tel. 714.545.5550  
Fax 714.545.5748

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential  
and will become part of your medical record.

<b>Name</b> ( <i>Last, First, M.I.</i> ):		<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>	
<b>Family Physician</b>				
<b>Previous or referring doctor:</b>				
<b>Date and Place of last Hospitalization:</b>				
<b>Reason for hospitalization:</b>				
<b>Past Psychiatric History</b> ( <i>past psychiatrist, therapist and psychiatric hospitalization</i> ):				

<b>Do you:</b>	Yes	No	Name	How Long	Last used
Drink					
Smoke					
Use substance					

### List any current medications:

<b>Medications</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Prescribe By</b>	<b>How Long: (years/months)</b>

### Family Psychiatric History:

<b>Illness</b>	<b>Mother</b>	<b>Father</b>	<b>Sister</b>	<b>Brother</b>	<b>Other</b>
Psychosis					

Depression					
Bipolarism					
Anxiety					
Schizophrenia					
Hyperactivity					
Inattention					
Obsession					
Compulsion					
Delirium					
Eating Disorder					
Post-partum					
Dementia					
Other					

**Family Medical History:**

Illness	Mother	Father	Sister	Brother	Other
Psychiatric					
Neurological					
Cardio-vascular					
Endocrinological					
Gastrointestinal					
ENT					
Surgical					
Respiratory					
Other					

**Patient Medical History:**

Have you had or do you presently have problems with any of the following?

Symptoms	Yes	No	Comments
AIDS/IMMUNE Deficiencies			
Anemia			
Asthma			
Bloody stools/urine			
Bronchitis			
Cancer or Tumors			
Chest pain			
Chronic constipation			
Chronic cough			



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**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.