Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all __________
Somewhat difficult _________
Very difficult _____________
Extremely difficult _________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT NAME _________________________________ DATE ________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________________ DATE: ______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	____	+ ____	+ ____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: ____________

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	________
	Somewhat difficult	________
	Very difficult	________
	Extremely difficult	________

A2663B 10-04-2005

Mind Care Services

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Last Name: First:	Middle:	Marital status: Single / Married / Divorced

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:	Other (Employer) no:
Occupation:	**Employer:**	**Email Address:**	

Referred to clinic by (Physician's/Facility Name):

INSURANCE INFORMATION

(Please give your insurance card and driver's license/identification card to the receptionist.)

Primary Insurance Type: Medicare Medi-Cal PPO HMO CASH

Please indicate name of primary insurance:

Subscriber's name:	Group no.:	Subscriber SSN:	Policy/Member no.:	Co-payment: $

Patient's relationship to subscriber: | **Other:** | **Subscriber Contact #:**

Secondary Insurance Type: Medicare Medi-Cal PPO HMO

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy/Member no.:

Patient's relationship to subscriber: | **Other:**

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mind Care Services or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**

INFORMED CONSENT TO PERFORM A PSYCHOLOGICAL EVALUATION

Welcome to Mind Care Services. This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

I understand that the information obtained in this evaluation is confidential and will not be released to any person or organization without my written permission. (This release is available in our office or may be completed with any individual whom you wish to give such access, and then provided to us.) The only exceptions to this policy are rare situations in which you are required by law to release information with or without my permission. These are: 1) if there is evidence of physical and/or sexual abuse of children or abuse to the elderly; 2) if you judge that I am in danger of harming myself or another individual; and 3) if my records are subpoenaed by the court. In the rare event of any of these situations, you would attempt to discuss your intentions with me before an action is taken, and you would limit disclosure of confidential information to the minimum necessary to insure safety.

CONFIDENTIALITY AGREEMENT

Privacy Policy Confidentiality is the legal right to privacy for all patients who receive psychiatric and psychological services. Such as, all personal information presented to this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law. However, there are exceptions to confidentiality. Please be advised, all information discussed in this office will remain confidential except under the following conditions set forth in this agreement:

● You consent in writing for Mind Care Services to release and disclose information.

● A breach of confidentiality is required or permitted by law. Examples include instances in which Mind Care Services has a reasonable suspicion of child abuse, elder/dependent adult abuse, dangerousness toward self or others, and other matters subject to law.

● Mind Care Services in their discretion decide to obtain consultation on your case with a colleague or legal counsel, in which case no identifying information will be revealed.

● You fail to make regular payments on your outstanding bill, which can result in your billing being turned over to a collection agency or submitted to small claims court.

● Upon notification of a social service agency case, wherein all information shared with Mind Care Services will be conveyed to the assigned social worker and/or other SSA representative and agents.

● If you are a party in litigation, including divorce litigation, and you tender your mental condition as an issue, your privilege may be waived. In custody case you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. We may be required to produce your records and/or testify at deposition or trial if we are served with subpoenas or court orders. We cannot give you legal advice as to what action may or may not waive your privilege.

● Please be aware that under California's Family Code, a parent without custody may still be entitled to information about his or her child's treatment.

_______ **Initial**

NOTE TO PARENTS ABOUT CHILDREN'S CONFIDENTIALITY

If your child participated in treatment, it is important to allow him/her to develop a confidential relationship with his/her psychiatrist and/or therapist. As such, you understand that most personal information that your child discusses with his/her therapist will not ordinarily be shared with you. Rather your child's doctor will provide you with general summaries of your child's progress without private details. This office is committed to informing you about unusual or dangerous symptoms or behaviors (such as violence, child abuse, self-abuse, suicidality, or intentions to harm others, harm oneself, drive while intoxicated, etc.)

RELEASE OF RECORDS

Written records are released only after a consent form is signed by the client or their Parent/Legal Guardian.

APPOINTMENT POLICIES

Initial evaluations are generally about 30 to 60 minutes in duration. Subsequent follow-up session range from 15-30 minutes in duration. Medication management sessions are about 15 minutes in duration, based on a case-to-case basis. However these sessions may require more time than expected. All paperwork and submission of co-pay must be rendered before the beginning of the session. Please arrive 15 minutes before your scheduled appointment for ease of operations. Please respect time guidelines so that the next patient waiting is not affected.

24-HOUR CANCELLATION POLICY

You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.If you cancel your appointment with less than 24-hour notice, or if you do not show up for a scheduled appointment you will be charged a late cancelation/no show fee.This cancellation policy is standard in the medical and mental health fields and will be strictly enforced. On occasion, there will be understandable reasons for missing appointments, but exceptions to this policy will be rare. **<u>If you have three (3) no shows/late cancellations, we will discharge you from our care. Cancellation fees will be due at the time of your next scheduled appointment.</u>**

RIGHT TO END THERAPY

You have the right to end therapy at any time with no obligation expect to pay for completed services.

PRESCRIPTION REFILL POLICY

Medication refills are prescribed on a 30 day basis, you are responsible for keeping scheduled appointments in order to avoid medication shortages. **<u>Medication refills are not emergencies</u>**. If you run out of medicines due to unforeseen circumstances; please contact the office during regular business hours. Office staff will call in a partial refill on your non-controlled medications, provided that you have a scheduled follow-up appointment.If appointments are missed, no further early or partial refills will be authorized. Please be advised that controlled substance prescriptions cannot be called in. You will have to schedule an appointment in order to be given a new prescription. If medications are lost or stolen, police reports are mandatory for communications for refill requests.We can **<u>NOT</u>** guarantee that refills on lost or stolen medications will be filled by your pharmacy or paid by your insurance.

________ Initial

MEDICATION COMPLIANCE POLICY

All patients receiving controlled medications must consent to random urine toxicology screenings. Failure to do so could result in discharge from our clinic, Controlled medications are, but are not limited to stimulants, benzodiazepines and opioid dependence medications

________ **Initial**

FINANCIAL POLICIES

Professional services and rates: Our professional services and rates are as follows:

Professional Services	Times	Rates MD/DO	Rates for NP/ PhD	Rates for LCSW/LMFT
Initial Visit	30-40 min 60 min Therapy	$400	$250	$150
Follow Up	15-20 min 60 Min	$250	$150	$150
Missed Appointments	No Call/No Show	$50	$50	$50

Forms, letters, and other non specific

Forms, Report Writing (Treatment summaries, disability, letters, etc.) Conservatorship Forms	Prorated	*Varies by document	*Varies by document	*Varies by document
Court-Related Services: (any court-related services, including evaluation, depositions, conferencing, testimony, preparation, standby and travel time, reports to be used for legal purposes etc.)	Prorated Half-Day minimum for court attendance or standby status. Retainer required in advance. RETAINER FEE To be paid prior to court Date.	$800 (Varies by Case) $2000 (Varies by Case)	$400 (Varies by Case) $1000 (Varies by Case)	$400 (Varies by Case) $1000 (Varies by Case)

FINANCIAL TERMS

Please note, you are responsible for obtaining prior authorization for treatment from your insurance company. In addition, you are responsible for all co-pays and insurance services when rendered. Furthermore, I understand I am responsible for charges not covered by my insurance. I further agree if at any time during my treatment, I become aware that I am ineligible for insurance coverage, I will notify the office of such changes.

PAYMENT TERMS AND UNCOVERED SERVICES

I understand I will be charged the cash rates for services required outside of the treatment sessions. I will be charged a fee for conservatorship, petitions, disability forms, or any letter that is required for medical leave. Please be advised, should it become necessary for Mind Care Services to employ an attorney to enforce any of these conditions hereof, I understand I will pay any/and all expenses so incurred included reasonable attorney fees.

Types of Payment.Services are to be paid prior to appointment. Please make checks payable to Mind Care Services. Also for your convenience, you may pay by cash or credit card.

Prompt Payment. Balances not paid within 30 days are considered “PAST DUE”. Balances not paid within 60 days may be sent to our collections agency or pursed through small claims court. IF you are not able to make a full payment, you agree to make regular payments no less than $100.00 until the balance is paid in full.

Insurance Claims. Please note, you are required to pay for all services rendered not covered by your insurance carrier.

________ Initial

PSYCHIATRIC EVALUATION CONSENT

By my signature below, I acknowledge that I consent to a psychological evaluation by Mind Care Services that I have been informed of the policies regarding evaluations at the clinic and have read the consent form as well as the policies regarding late/cancellation and missed appointments and refills; I agree to all of the payment arrangements outlined in this form. I fully understand my rights and obligations as a client at MCS and I freely agree to this assessment.

______________________	______________________	______________________
Signature	Name	Date
______________________	______________________	______________________
Guardian Signature/ Relationship	Name	Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: _______________

Witness: ____ Date: _______________

Mind Care Services

Credit Card on File Policy

We have implemented a policy requiring a credit card held on file effective Feb 1, 2019. This card can/will be charged for the following reasons:

-Visit payments not collected from you at the beginning of your visit

-No show or late cancellation charges

-Insurance discrepancies that are not resolved within 90 days of the date of service

-Outstanding balance greater than 90 days past due

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Patients with verified **ACTIVE MEDICAID** coverage are exempt from having a credit card on file.

If you have any questions about this payment method, do not hesitate to ask.

Authorization for Credit Card On File Payment

Until further notice, I authorize Mind Care Services to charge the patient-responsible balances (co-pays, co-insurance, deductibles, non-covered services, no show or late cancellations) on my account to the following credit card (If the balance due is more than $100.00, I will receive a courtesy call prior to my card being charged) :

Circle one: Visa Mastercard Discover American Express

Card Number:____ Exp. Date (mm/yy):__________

CVV: ___________ Billing Zip Code _________________

Signature:_________________________ Date: ____________ Printed Name:___________________________

Email for receipts:____

Mind Care Services

Paperwork/Forms Request Policy

Please speak with your provider prior to requesting any forms/letters. Requests will be completed within **7-10 business days**. NO EXCEPTIONS.

Office staff will contact you once forms/paperwork/letters are completed.

Fees are to be paid at the time of request, **NO REFUNDS GIVEN**.

FMLA/EDD -Initial/Extension Extension/Recertification	**$25** **$15**
SSDI Questionnaire	**$75**
Physician's Statement Form	**$25**
DMV- Driver Medical Evaluation	**$50**
USCIS Forms (Immigration) Capacity Declaration Form (Conservatorship)	**$100** **$250**
Emotional Support Pet Letter (Must provide proof of vaccinations and registration)	**$150**
Letters- Treatment,Diagnosis/Time Off/Misc. Other Court Related Documents	**$10** ***Varies***

I acknowledge that I been informed of Mind Care Service's policy regarding Form/Paperwork/Letter Requests and Fees applicable; and I agree to all outlined in this form. If you have any additional questions regarding forms, please speak with front office staff.

Signature ______________________________ **Date** ______________________

333 W. Broadway Suite 310 Long Beach, CA 90802
Office : 562-491-6465 Fax: 562-590-6463