Harbor Psych

Harbor Psychologists and the Office of Jorge Dubin, M.D.

New Patient Information and Consent

Form to be completed by patient (or parent/ guardian if patient is under age 18)
All Information MUST be completed

Patient Name:_____ **Today's Date:**_____

Date of Birth:_____ **Age:**_____ **Male**☐ **Female**☐ **Social Security #:** _____

Address:_____

City: _____ **State:**_____ **Zip Code:** _____

Phone- Home:_____ **Work:**_____ **Cell:**_____

May we call your home? Yes☐ No ☐ **May we call your work?** Yes☐ No☐ **May we call your cell?** Yes☐ No☐
May we text your cell? Yes☐ No☐

Marital Status: Single ☐ Living Together ☐ Married ☐ Partners ☐ Separated ☐ Divorced☐ Widowed ☐

Employer/School:_____**Occupation**:_____

Financial Responsibility (insured person, person responsible for payment)

Insured's Name:_____ **Insured's Social Security #:**_____

Insured's Date of Birth:_____ **Relationship to patient**:_____

Address (if different than patient) _____

City: _____ **State**:_____ **Zip Code**: _____

Contact Phone Number (if different than the patient) _____

Insurance Company: _____ **Phone #** _____

Member ID# on Insurance Card:_____ **Group #:**_____ **Policy:**_____

Mental Health Carrier:_____ **Mental Health Phone #:** _____

Initial Authorization #:_____ **Employer:**_____

Secondary Insurance Company:_____ **Phone #** _____

Insured's Name:_____ **SS#:**_____ **Group:**_____

Person to Contact in Case of Emergency

Name:_____ **Relationship to Patient:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

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MEDICAL HISTORY

Primary Care Physician: _____ **Phone Number:** _____

Date Last Seen: _____ **Reason for Last Visit:** _____

_____

Please list any medications you are currently taking: _____

_____

_____

Please list any past or present medical conditions for which you have been treated:_____

_____

_____

_____

Presenting Problem(s) - Please describe your reason for seeking treatment at this time and include when the problem started: _____

_____

_____

_____

_____

Was there an event which caused these problems? Yes ☐ No ☐

If Yes please explain:_____

_____

_____

_____

Allergies: ☐Yes ☐NKA (No Known Allergies)

If Yes Please List Them: _____

_____

_____

_____

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Please read and individually acknowledge each section by initialing on the line to the left, and sign at the bottom

_____ **Financial Terms and Assignment of Benefits**

Upon verification of insurance coverage and policy limits, your insurance will be billed for you and your provider will be paid directly by the carrier. Upon acceptance of your appointment it will be the patient's responsibility for any and all fees. Payment is due at the time services are rendered. If you are without insurance coverage, payment arrangements should be made prior to your first appointment.

_____ **Canceled / Missed Appointments**

When scheduling an appointment, a time is set aside specifically for you. If you cancel or do not keep your appointment without giving 48 hour notice – or by Friday at noon for a Monday appointment, you will be charged $70. If two appointments are cancelled or missed consecutively, you may be in non-compliance and may be referred back to your insurance company to find a new provider.

_____ **Appeals and Grievances**

You have the right to request reconsideration in the case that outpatient care (number of visits) is not authorized. This is called an appeal. You can request and appeal though your provider. You have the right to submit a Grievance directly to your provider or to the Clinical Group to which they belong at any time that you have a complaint about any aspect of your care. If you are not satisfied with the response you receive, you may submit the Grievance to your health plan directly.

_____ **Emergencies**

If you are in imminent danger call 911, your nearest police department or go to a hospital emergency room. For all other emergencies please call the Los Angeles County Crisis Line at 800-854-7771.

_____ **Confidentiality**

All information between therapist/ Doctor and patient is held strictly confidential unless:

You authorize release of information with your signature (or parent/ guardian)

You present a physical danger to self

You present a physical danger to another

Child, elder or disabled individual abuse is suspected

In the latter two cases, we are required by law to inform potential victims and legal authorities so protective measures can be taken. The Notice of Privacy Practices is being provided as required by HIPPA. You may request a paper copy at any time.

_____ **Consent for Treatment**

"I authorize and request that my Provider(s) carry out psychological examinations, treatments and/ or diagnostic procedures, now and during my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me. I also understand that while the course of my treatment is designed to be helpful, it may at times be difficult and uncomfortable."

_____ **Release of Information to my Insurance Company**

"I authorize the release of information for claims, certification/ case management, and other purposes related to the benefits of my Health Plan."

I understand and agree to all of the above information.

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices and that I have read and understand all of the above information.

_____	_____	_____
Signature of Client (Parent or Guardian if Client is a minor)	Date	Provider signature