



# 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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**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 a minimum of \$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 through 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 or elder 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 or during my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. 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**

"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.**

Print Patient (Parent/Guardian) Name

Patient Signature/Date

Provider Signature



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## MEDICAL HISTORY

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date Last Seen: \_\_\_\_\_ Reason for Last Visit: \_\_\_\_\_

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Please list any medications you are currently taking: \_\_\_\_\_

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

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

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Was there an event which caused these problems? Yes  No

If Yes please explain: \_\_\_\_\_

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Allergies: Yes NKA ( No Known Allergies)

If Yes Please List Them: \_\_\_\_\_

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