Michele Z. Abbasi, M.D.
32129 Lindero Canyon Road, suite 108A
Westlake Village, CA 91361
Phone: (818) 272-8005 Fax: (818) 272-8005
mzabbasimd@gmail.com

PERSONAL INFORMATION SHEET

Name:____
Last First Middle Initial

Address:____
Street City Zip

Home phone:____________________ Cell phone:______________________

Work phone:__________________ (Put * next to preferred # for messages to be left at)

Date of Birth:___________ Social Security No.:____________________________

Email: ____

Marital Status – Circle one: Single / Married / Divorced / Widowed / Separated / Domestic Partner

Emergency Contact Name:________________________ Phone: _______________

Employed By:___________________ Occupation:________________________

Business Address:____
Street City Zip

Pharmacy Name:_______________________ Phone: _____________________

Primary Care Doctor: _________________________Phone: __________________

Current Therapist: __________________________ Phone: __________________

Medical & Psychological Diagnoses:_______________________________________

____

Current Symptoms:____

Allergies to medications- names and reactions:_______________________________

Insurance Provider:________________________ ID#_____________________

Group #________________________ Subscriber Name:____________________

Relationship to subscriber:____

Referred by:___________________________ May I thank them? ____Yes _____No

Signature:_____________________________ Date:___________________

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MEDICAL HISTORY

Patient Name:____________________________________ Date:_______________________

Date of Birth: _________________ Allergies to Medications:_________________________

HISTORY OF MEDICAL PROBLEMS (If yes, check box, identify, and write past or present)

□ Headache _____________________ □ Hepatitis _____________________ □ Arthritis _________________________

□ Head injury ___________________ □ Appetite/Weight Change_________ □ Cancer ___________________________

□ Loss of Consciousness___________ □ Thyroid _______________________ □ Skin _____________________________

□ Asthma _______________________ □ Diabetes_______________________ □ Eye _____________________________

□ Shortness of breath_______________ □ Kidney Disease ________________ □ Ear ______________________________

□ Cardiovascular ________________ □ Urinary _______________________ □ Polio ____________________________

□ Abnormal Blood Pressure _________ □ Seizures ______________________ □ Abnormal Lab Tests ________________

□ GI disorder ____________________ □ Withdrawal Seizures____________ □ Sexual Problems____________________

□ Constipation____________________ □ Frequent Infections ______________ □ Enuresis/Encopresis_________________

□ Diarrhea_______________________ □ Anemia _______________________ □ Other ____________________________

□ Family History of Cardiac Disease, Thyroid, Diabetes, or Headache____

____

Are there any other problems or symptoms that I should be aware of? ____

____

WOMEN ONLY

Regular Menstrual Cycles? □ Yes □ No PMS Symptoms:________________________

Currently Pregnant? □ Yes □ No Planning pregnancy? □ Yes □ No Date of Last PAP? ________________

MEN ONLY

It's common to occasionally experience erection or ejaculation difficulties. Is this something that happens to you? □ Yes □ No

How often does this occur? □ Frequently □ Sometimes □ Rarely

HABITS

□ Smoking: # Cigarettes/day_______ □ Coffee: Cups daily___________ □ Sleep: Difficulty falling asleep __________

Years smoking_________ Other caffeine ________ Difficulty staying asleep __________

Tried stopping?________ □ Alcohol: Types_____________ Snoring ____________

□ Exercise: What kind ____________ Amount daily________ Early morning awakening _________

Minutes per day________ Amount Weekly______ □ Special Diet: _____________

Days per week_________ □ Substance Use: ___________________

HOSPITALIZATION OR SURGERY

Reason(s):____ Date: ______________________

Reason(s):____ Date: ______________________

CURRENT MEDICATIONS & SUPPLEMENTS (please attach additional page if necessary)

____

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OFFICE POLICIES AND PROCEDURES

Confidentiality:
With the exception of certain situations described below, what you share in the context of psychiatric services will be kept in confidence. Without your written permission, we cannot divulge your personal information to anyone. You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures confidentiality of all electronic transmission of information about you. We use safeguards to insure confidentiality when transmitting information about you electronically.

The following are legal exceptions to your right to confidentiality. We would inform you of any time when we think we will have to put these into effect.

1. If in the course of your participation in psychiatric services we have good reason to believe that you will harm another person, we must attempt to inform that person (or persons) and warn them. Further, we must also contact the proper authorities so that they may protect the targeted party (parties).

2. If we have good reason to believe that you are abusing or neglecting a child (under age 18), elder (over age 64) or gravely disabled adult, ***or*** if you give us information about *someone else* who is doing this, we must inform the appropriate protective services organization within 48 hours.

3. If we believe that you are in imminent danger of harming yourself, we may legally break confidentiality and call the police or a crisis team. We would explore all other options with you before taking these steps. If after exploring other options you indicate that you are unwilling to take steps to make yourself safe, we would contact the proper authorities.

4. If you have signed a consent form legally authorizing us to discuss your progress, treatment outcomes, and treatment history with another provider, then we may share this information with those parties to help facilitate optimal care.

**Please initial here to acknowledge your understanding of the conditions under which confidentiality may be broken. ______________________

Record-keeping:
Our policy regarding record keeping is to provide brief, relevant records of your attendance, relevant concerns, treatment planning, and progress. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time and can request in writing that we correct any errors in your file. You must tell us the reasons you want changes to be made. You have the right to make a written request that we make a copy of your file available to any other health care provider. Please be aware that we may charge you when making copies of your records. Your records will be maintained in a secure location that cannot be accessed by anyone else.

Payments, Fees, and Cancellation Policy:

Payment is due at every session. We accept cash, personal checks, Master Card, Visa and Discover. For **checks returned** by the bank, we assess a $35 NSF charge. Accounts with balances more than 30 days past due will be charted 1.5% interest per month. Accounts with balances more than 3 months past due will be turned over to a collection agency and reported to credit bureaus. Credit cards may be kept on file to

guarantee payment and will not be charged without notification.

Please be on time for your appointment so you can use all of your allotted time. If you are late your appointment will still end at the scheduled time. **Missed appointments and appointments not cancelled within 48 business hours will be billed the full fee.** We understand that personal schedules change, however, the time slot has been saved for you.

Dr. Abbasi is not contracted with insurance companies. Services are not rendered on the basis that your insurance company will reimburse you. If you have insurance, you will be provided with an insurance statement to submit to your insurance company, but you are responsible for payment in full. Submission of a statement to your insurance company does not automatically guarantee reimbursement. Check your health insurance coverage for Out-of-Network outpatient mental health care to determine your possible reimbursement.

Telephone calls are recognized as patient care by the American Medical Association and **may replace the need for an office visit at the doctor's discretion**. Telephone calls, emails, document preparation, and other requirements of your doctor's time and expertise lasting longer than 5 minutes will be charged at his/her hourly rate (prorated). **Emails are not considered to be patient care and may not substitute for actual doctor/patient contact.**

*Please initial to acknowledge your understanding of our Payments, Fees, and Cancellation policy________

Discontinuation of Treatment:

Typically a patient decides when to end treatment, which may be done at any time in person, in writing or by phone. There are some exceptions to this. Your provider will usually discontinue treatment only after discussing it with you and usually for one of the following reasons:

1. Failure to pay for services rendered
2. Cancelling too often
3. Non-compliance with recommended treatment
4. You are in need of a higher level of care due to engaging in dangerous behavior (self-harm, harm to others, chronic suicidal intent and/or actions, excessive or inappropriate drug/alcohol use, etc.).

**Please initial here to acknowledge your understanding of the conditions under which services may be discontinued. _______________

Provider Conduct:

Dr. Abbasi will not and does not have social or sexual relationships with patients or former patients because it is unethical and illegal.

Statement of Patient:

I have read, understand and agree to the above policies. Dr. Abbasi has reviewed this form with me and has answered any questions that I have and I am being provided with a copy of this form.

____

Client Signature Date

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MEDICATION POLICY

In order to effectively manage your medication, please be aware that the following guidelines must be followed:

1. In order to receive refills of your medications, you are responsible to make an appointment to see your psychiatrist **in person** for a session at least once every 1-3 months, frequency as assessed by your psychiatrist.

2. Adult patients are responsible for getting blood work done once a year. We can order this for you, or you may have your primary physician order it.

3. It is your responsibility to notify your psychiatrist immediately of **any** side effects of your medication.

4. Your psychiatrist will need to be advised any time another physician starts you on a new medication, or there is a change in your health status.

5. Insurance companies allow only a 30 day supply of medication at a time unless you use a mail away prescription plan which allows a 60 or 90 day supply.

6. Please anticipate any refill needs and discuss it during the office visit.

7. Please ask your pharmacy not to enroll you in automatic refill requests to my office.

8. **Requests for refills may take up to 48 hours to be available at your pharmacy and are not done on weekends or holidays.**

"I have read and understand the above policies."

____ ____________________
Signature of Patient or Responsible Party (if patient is a minor) Date

____
Patient Name

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PROFESSIONAL FEES AND SERVICES

Michele Z. Abbasi, MD

Initial Adult Evaluation*

80 min. session with patient	$495

Initial Child and Teen Evaluation*

50 min. session with parents	$345
50 min session with child / adolescent	$345

Individual Therapy With or Without Medication Management

25 min. session	$225
45 min. session	$345

Telephone Consultation and Other Services*

> 5 minutes, time is billed at a prorated rate of $460.00 per hour

* Fees include: collecting and reviewing past records, communicating/coordinating with other entities such as therapists, physicians, schools and insurance companies, and record–keeping of said communication

"I have read, understand and agree to the above."

____ ____________________
Signature of Patient or Responsible Party (if patient is a minor) Date

____
Patient Name

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CREDIT CARD INFORMATION

I, ____, authorize Dr. Abbasi to charge my credit card for outstanding balances on my account due to late cancellations, no show appointments, returned checks, credit card charge backs, and past due accounts. I understand that every attempt will be made to notify me before a charge is made. (American Express not accepted.)

Name as it appears on card:____

Credit Card# ____

Expiration Date: _________________ Security Code: _______________ Visa MasterCard Discover

Street Address for credit card billing ____

Zip Code for credit card billing __________________________________

Signature ____

Date ___________________________

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PATIENT EMAIL CONSENT FORM

Patient Name: _________________________ Patient Email: ___________________________________
Responsible Party Email (if patient is a minor): ____

1. Risk of Using Email
   Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:
   a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b) Email senders can easily misaddress an email.
   c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
   d) Employers and online services have a right to inspect email transmitted through their systems.
   e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
   f) Email can be used to introduce viruses into computer systems.
   g) Email can be used as evidence in court.
   h) Email may not be secure, and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions For the Use of Email
   Dr. Abbasi cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider’s intentional misconduct. Patients must acknowledge and consent to the following conditions:
   a) **Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.**
   b) Email must be concise. The patient should schedule an appointment to discuss clinical issues.
   c) Emails may be printed and filed in the patient’s medical record.
   d) Office staff may receive and read your email messages.
   e) Provider will not forward patient identifiable emails to other healthcare providers without the patient’s prior written consent, except as authorized or required by law.
   f) The patient should not use email for communication regarding sensitive medical information.
   g) Provider is not liable for breaches of confidentiality caused by the patient or any third party.
   h) It is the patient’s responsibility to follow up and/or schedule an appointment if warranted.

3. Instructions
   To communicate by email, the patient shall:
   a) Avoid use of his/her employer’s computer.
   b) Put the patient’s name in the body of the email.
   c) Key in the topic (e.g., billing question) in the subject line.
   d) Inform Provider of changes in his/her email address.
   e) Acknowledge any email received from the Provider.
   f) Take precautions to preserve the confidentiality of email.

4. Patient Acknowledgment and Agreement
   I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Provider and me, and consent to the conditions and instructions outlined. If I have any questions I may inquire with Dr. Abbasi.

____   ____________________
Signature of Patient or Responsible Party (if patient is a minor)   Date

____
Name of Patient

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CONTACT INFORMATION CONSENT

Due to the new privacy laws, we are required to ask you for clarification about our calls to your home, office or cell phone regarding things like appointments, test results, medication side effects and prescriptions. Please answer these questions and sign and date this form. If this information should at any time need to be modified, please call us and we will be happy to assist you.

1) WITH WHOM MAY WE SHARE MEDICAL INFORMATION?

___________ MYSELF ONLY

___________ SPOUSE OR SIGNIFICANT OTHER – Name: _______________________________

___________ PARENT OR LEGAL GUARDIAN – Name: _________________________________

___________ OTHER – Name and relationship:____

2) WHERE AND WITH WHOM MAY WE LEAVE A MESSAGE FOR YOU?

____
Name Phone

____
Name Phone

SIGNATURE: _____________________________________ DATE: _____________

PATIENT NAME: ____

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HIPAA NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act ("**HIPAA**") requires that we maintain the privacy of your medical information and provide you this notice in writing of our privacy practices.

We value the confidentiality of your personal health information ("PHI"). Your health information includes records that we create and obtain when we provide care to you, including records of your symptoms, examination and test results, diagnosis, treatments, and referral for further care, in addition to bills and payment information, and insurance claims that we maintain related to your care. This notice describes how physical and mental health information about you may be used and disclosed, your rights regarding this information, and how you may access this information. Please review it carefully. Any questions should be directed to our office at: 32107 Lindero Canyon Road, suite 209 Westlake Village, CA 91361 (818) 272-8005.

Consistent with HIPAA and California law, we are required to:

- Maintain the privacy of protected health information as required by law.
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the Notice currently in effect.

It is the policy of our office that a notice of privacy practices is provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this office's notice of privacy practices.

The following describes the way we may use and disclose your health information. Except for the following purposes, we will use and disclose your health information only with your written permission. You may revoke this permission at any time by writing to our office.

It is our policy of that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance, such uses and disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also our policy that non-routine uses and disclosures will be handled pursuant to established criteria. It is also our policy that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.
We may use and disclose your physical and mental health information for your treatment and to provide you with treatment-related health care services. We may use and disclose your physical and mental health information to contact you and remind you of your appointment times, to advise you of treatment alternatives, health related benefits, or other services you could use. We will disclose your physical and mental health information when required to do so by international, federal, state or local law.

It is our policy to require an authorization for any use or disclosure of psychotherapy notes, as defined in the HIPAA regulations, except for treatment, payment or health care operations as follows:
A. Use by originator for treatment;
B. Use or disclosure in defense of a legal action brought by the individual whose records are in issue;
C. Use or disclosures as required by law, or as authorized by law to enable health oversight agencies to oversee the originator of the psychotherapy notes.
In most cases, when we receive a request to disclose psychotherapy notes, it is our policy to provide copies of psychotherapy notes to the patient, along with the information of the entity requesting the notes, allowing the patient to provide the notes to the requesting entity.

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You have the right to inspect and/or receive a copy of your physical and mental health information and billing records, except in very limited circumstances. You have the right to request an amendment to your records. You have the right to an accounting of disclosures of your PHI. All requests should be made in writing to this office.

We may change this notice and make it effective for medical information we already have in addition to new information we may obtain from you. You have a right to request a paper copy of the current notice at any visit or by written request to this office.

If you have any questions or complaints regarding your privacy rights, please contact this office at: 32107 Lindero Canyon Road, suite 209 Westlake Village, CA 91361 (818) 272-8005. If you believe your privacy rights have been violated, you may file a complaint with Dr. Abbasi. To file a complaint with the Secretary of the Department of Health and Human Services contact the: Department of Health and Human Services, Office of Civil Rights, South United Nations Plaza, Room 322, San Francisco, CA 94102, PHONE (415) 437-8310. (FAX) (415) 437-8329, (TDD) (415) 437-8311. *You will not be penalized for filing a complaint*.

32107 Lindero Canyon Road, suite 209
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Phone and Fax: (818) 272-8005

Patient Acknowledgement of Receipt of
HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices of Dr. Abbasi, effective October 22, 2007.

____
Signature of Patient or Responsible Party

____
Print Name of Responsible Party (and Minor)

____
Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Accounting of Disclosures Tracking Form

I, ____ **OR**
Print Name of Patient   Birthdate

I,____
If patient is under 18 years of age print Name of **Parent(s) or Guardian**

hereby authorize:

☐ Michele Z. Abbasi, M.D.

to exchange my personal health information with:

☐

Name of Agency/Person/Organization   Address (No. Street, City, State & Zip)   Telephone No. and Fax No.

☐ Other:

Name of Agency/Person/Organization   Address (No. Street, City, State & Zip)   Telephone No. and Fax No.

with the knowledge that such contact discloses the fact that mental health/substance abuse services have been/are being provided. This disclosure of information is required for the following purpose(s):

☐ Evaluation   ☐ Treatment Planning/Course   ☐ Other____

and will consist of the following types of information:

☐ Entire Record   ☐ **Dates and Results** of Medical Assessments and Diagnoses, Lab Tests, EEG, EKG
☐ Medication History   ☐ Results of Psychological Testing
☐ Discharge Summary   ☐ Educational Information
☐ Legal Information   ☐ Other _________________________________

The information and records released pursuant to this consent will not be used for any other purpose.

This consent becomes effective _____________________. This consent may be revoked by the undersigned at any time **in writing**. If not revoked, it shall terminate at the end of treatment with Dr. Abbasi. I understand that I may receive a copy of this authorization. There is a risk that the person receiving information or documents pursuant to this authorization may re-disclose the information and documents in a manner which will no longer provide protection for the information and documents.

____   Date: _____ /_____/_____
Signature of Client   Month Day Year

____   Date: _____/_____/_____
Signature of Parent, Guardian or Conservator   Month Day Year

____   Date: _____ /_____/_____
Signature of Other Parent (if legally necessary)   Month Day Year

RECORD OF RELEASE OF INFORMATION

____   _________________________________
Released By (Name and Title)   Date Released

All requests for release of information must be in writing. If there are any parties to which you do not want to release this information, please complete a Request for Special Privacy Protection (HF 04a).