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- Minor

Name of Patient:_____ Date of Birth:_____

School currently attending:_____Grade:_____

Child's Cell #: _____ Child's Email:_____
Child lives with: ____Mother ____Father ____ Both ____Guardian
Who has legal custody: ___Mother ____Father ____ Both ____Guardian

Mother Name:_____

Address:_____
street city zip

Home phone:_____ Work phone:_____

Cell phone:_____ Email address: _____
(Put * next to preferred # for me to leave you messages)

Stepfather Name:_____ Phone:_____

Father Name:_____

Address:_____
street city zip

Home phone:_____ Work phone:_____

Cell phone:_____ Email address: _____
(Put * next to preferred # for me to leave you messages)

Stepmother Name:_____ Phone:_____

Pediatrician- Name & No.:_____

Pharmacy/Telephone No.:_____

Insurance Company & ID#_____

Referred by:_____
May I thank them? _____yes _____no

Signature of parent/guardian:_____ 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? _____

_____

FEMALE CHILDREN ONLY

Does your child have Regular Menstrual Cycles? □ Yes □ No PMS Symptoms:_____

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

MALE CHILDREN ONLY

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

How often does this occur? □ Frequently □ Sometimes □ Rarely □ Don't know

HABITS: Please describe your child's typical 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

_____

_____

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OFFICE POLICIES AND PROCEDURES

The following confidentiality and office procedures apply to patients being treated by Dr. Abbasi.

Confidentiality:
With the exception of certain situations described below, what your child shares in the context of psychiatric services will be kept in confidence unless it is mutually agreed upon to discuss it with others. However, as a parent and/or guardian, you have a legal right to pertinent information about your child's treatment. Before beginning treatment, it is important to discuss with your child and their provider exactly what the expectations of privacy and confidentiality are. Without your written permission, we cannot divulge your child's personal information to anyone, including other providers who are directly involved in his/her care. Your child is 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 your child. We use safeguards to insure confidentiality when transmitting information about your child 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 child's participation in psychiatric services we have good reason to believe that they 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, based on information shared in treatment, that a child (under age 18), elder (over age 64) or gravely disabled adult is being abused or neglected, we must inform the appropriate protective services organization within 48 hours.

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

4. If you have signed a consent form legally authorizing us to discuss your child's 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 limits of confidentiality_____

Record-keeping:
Our policy regarding record keeping is to provide brief, relevant records of your child's 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 child's file at any time and can request in writing that we correct any errors. You must tell us the reasons you want to make the changes. 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 child's records for other providers. Your child's records will be maintained in a secure location.

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Payments, Fees, and Cancellation Policy:

Payment is due at every session. Dr. Abbasi accepts cash, personal checks, Master Card, Visa and Discover. For **checks returned** by the bank we assess a $35.00 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 hours will be billed the full fee.** We understand that personal schedules change, however, the time slot has been saved for you.

Dr. Abbasi 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 a form of 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 child's provider'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 child's 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. Your child is in need of a higher level of care due to engaging in dangerous behavior (self-harm, harm to others (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 therapy services may be discontinued. _____

Provider Conduct:
Dr. Abbasi will not and does not have social or sexual relationships with patients or former patients because that is not only unethical and illegal, it would be an abuse of the power that we hold as a mental health professionals.

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.

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_____

Client Signature Date

_____

Printed Name

If client is under the age of 18, parent/guardian acknowledges reading this document and consents to the contents therein as applied to the minor participating in therapy.

_____

Parent/Guardian Date

_____

Printed Name

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MEDICATION POLICY

For patients being treated by a psychiatrist:

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

1. In order to receive refills of your child's medications, you are responsible to make an appointment for your child to see his/her psychiatrist **in person** for a session at least once every 3 months (**once his/her medications and doses are stable**).

2. It is your responsibility to notify your child's psychiatrist immediately of **any** side effects of your child's medication.

3. Your child's psychiatrist will need to be advised any time another physician starts him/her on a new medication, or there is a change in his/her health status.

4. 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.

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

6. Please ask your pharmacy not to enroll your child in automatic refill requests to my office.

7. **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.

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

We value the confidentiality of your child's personal health information ("PHI"). Your child's health information includes records that we create and obtain when we provide care to your child, including records of 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 child's care. This notice describes how physical and mental health information about your child 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 child's 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 are 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.
You have the right to inspect and/or receive a copy of your child's 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.

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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
Westlake Village, CA 91361
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 8, 2012.

_____
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 Abbasi, M.D. to exchange my personal health information with:

☐ _____

☐ 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_____ ☐ Other_____

and will consist of the following types of information:

☐ Entire Record
☐ Medication History
☐ Discharge Summary
☐ Legal Information
☐ **Dates and Results** of Medical Assessments and Diagnoses, Lab Tests, EEG, EKG
☐ Results of Psychological Testing
☐ Educational 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 your Calabasas Behavioral Health provider(s). 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).