PATIENT INFORMATION
TERRENCE EARLY MD

PATIENT			
NAME (First, Last)* (As Shown by Insurance)	MI:	Date Of Birth:	
Preferred/Other Name:		SSN:	
Address:	City:	State:	Zip:
Circle **Home** / **Mobile** / **Work** to indicate where confidential messages can be left.		Email:	
Home: ( )		Sex/Gender:	
Mobile: ( )		Marital Status:	
Work: ( )		Other:	

EMERGENCY CONTACT		
Name:	Relation:	Phone:

PRIMARY INSURANCE		
Insurance Company:	Ins. ID #:	
Group Name(if one):	Group #:	Employer/School (if one):
Subscriber's Name:	Relation:	Subscriber DOB:

SECONDARY INSURANCE		
Insurance Company:	Ins. ID #:	
Group Name:	Group #:	Employer/School (if one):
Subscriber's Name:	Relation	Subscriber DOB:

ACCOUNT RESPONSIBLE/GUARANTOR/PAYOR (IF OTHER THAN PATIENT)			
Name:	Relation:	Phone:	
Address:	City:	State:	Zip:

I certify to the best of my knowledge that all information provided is true and correct.

Name _____ Signature _____ Date _____

Interventional Psychiatry Associates
Mailing Address P.O. BOX 2010
Santa Barbara, CA 93120
Corporate Offices
31 E Audubon Rd.
Columbia MO, 65201
805-845-8770
www.ipasb.com

Recipient's Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a patient. The information contained in this form explains your rights as a patient, in regards to health records, grievances and complaints, and ethical obligations.

Your rights as a patient

1. Complaints. We will investigate your complaints.
2. Suggestions. You are invited to suggest changes in any aspect of the services we provide.
3. Civil rights. Your civil rights are protected by federal and state laws.
4. Cultural/spiritual/gender issues. You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
5. Treatment. You have the right to take part in formulating your treatment plan.
6. Denial of services. You may refuse services offered to you and be informed of any potential consequences.
7. Record restrictions. You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
8. Availability of records. You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records. If so, we will discuss this decision with you.
9. Amendment of records. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
10. Medical/legal advice. You may discuss your treatment with your doctor or attorney.
11. Disclosures. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Your rights to receive information

1. Medications used in your treatment. We will provide you with information describing any potential risks of medications prescribed at our facility.
2. Costs of services. We will inform you of how much you will pay.
3. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services at our clinic
4. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.

Our ethical obligations

1. We dedicate ourselves to serving the best interest of each client.
2. We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. We maintain an objective and professional relationship with each client.
4. We respect the rights and views of other mental health professionals.
5. We will appropriately end services or refer clients to other programs when appropriate.
6. We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
7. We respect various institutional and managerial policies but will help to improve such policies if the best interest of the client is served.

Name	Signature	Date

Fee Schedule

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Name: _____ Date of Birth: _____

I certify that the information given by me is true and correct and to the best of my knowledge. I authorize the release of all records required to act on request for payment from any and all third party sources. I understand that it is my responsibility to obtain any insurance preregistration and verify my insurance benefits. I request payment of any authorized benefit be paid on my behalf to TERRENCE EARLY MD.

I understand and agree to make best efforts to assist and secure payments for services under any insurance coverage available to me. I understand that I am responsible for any deductions from payments due to TERRENCE EARLY MD. because of limitations in my existing insurance coverage or my current financial status. I understand that any services charged directly to me are the following rates.

CPT	Description	Charge
	INTRA MUSCULAR KETAMINE TREATMENTS	$500.00
90792	Initial Psychiatric Diagnostic Evaluation	$ 450.00
99213	E&M Established Patient - Minor	$ 150.00
99214	E&M Established Patient - Moderate	$ 180.00
99215	E&M Established Patient - Complex	$ 230.00
90833	+ Psychotherapy 15 - 20 Min	$ 110.00
90836	+ Psychotherapy 30 - 45 Min	$ 200.00
90838	+ Psychotherapy 45 - 60 Min	$ 275.00
99021	E&M Consult	$ 85.00
M0064	Evaluation & Management	$ 85.00
90839	Office Visit (Emergency)	$ 300.00
90853	Group Psychotherapy	$ 85.00
99070	Injections	$100.00
99441	Phone Appointment	$ 150.00

No Show or Cancellation less than 24 hours' notice $150.00

Charges with CPT Codes indicate they may be billed through insurance.

Without insurance pricing is $450 per hour, $225 per half hour and $150 per 15 minutes.

If your insurance does not cover services, you as the patient are responsible for total balance. We cannot grantee benefits.

I agree that I am responsible for the above listed Fee Schedule, and agree to pay them in a timely manner.

_____ _____ _____

Name Signature Date

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Consent for Psychotherapy Treatment,

I, _____, as a patient of TERRENCE EARLY MD am informed that TERRENCE EARLY MD recommends that I receive psychotherapy for the treatment of my illness of problems. He has informed me of the nature of the treatment and has explained to me the benefits and risks as well as alternative approaches for care (including psychotropic medication if clinically appropriate). I understand that although TERRENCE EARLY MD has explained the treatment to me there may be problems that develop. I understand that it is my responsibility to inform TERRENCE EARLY MD (or a member of his staff if he is unavailable) if there are any expected changes in my condition or if any problems arise relating to my treatment. I understand that I am not compelled to engage in psychotherapy and that I may decide to stop it at any time. It is my responsibility to notify TERRENCE EARLY MD if I decide to terminate treatment. I also understand that, although TERRENCE EARLY MD believes that psychotherapy will help me, there is no guarantee that my condition will improve.

On this basis, I authorize TERRENCE EARLY MD to provide psychotherapy at such intervals as he deems advisable.

_____	_____	_____
Name	Signature	Date

CONSENT FOR PSYCHOTHERAPY TREATMENT

Please read this form carefully. If you have problems reading it, ask to have it read to you.

TERRENCE EARLY MD, met with me and we discussed my symptoms and mental or behavioral problems that led me to seek psychiatric treatment at this time. TERRENCE EARLY MD advised me of the medications that are known to be of help in treating the symptoms and mental or behavioral problems such as mine.

He also discussed with me the risks and benefits of such medications and the likelihood of improvement or none with or without medication. TERRENCE EARLY MD advised me of the potential side effects of the medication(s) he has prescribed to me from the groups below. These side effects, include, but are not limited to:

Antipsychotics
Drowsiness, stiffness, muscle spasms, tremors, restlessness, dry mouth, constipation, blurry vision, uncontrollable body movements (tardive dyskinesia), weight gain, increase risk for diabetes or elevated lipids (cholesterol), light headedness, drooling, worsening of seizures, changes in blood pressure.

Antidepressants
Dry mouth, constipation, drowsiness, light-headedness, heart arrhythmia, nausea, diarrhea, decreased sex drive and function, headache, shakiness, restlessness, unsteadiness, weight gain, worsening of seizures, changes in blood pressure.

Mood Stabilizers/Anticonvulsants
Sedation, slowed thinking, unsteadiness, nausea, diarrhea, constipation, drooling, increase in liver enzymes, lowering of blood count, rash, changes in blood pressure, increased thirst and urination, decrease in thyroid function.

Sedatives/Antiolytics
Sleepiness, light-headedness, unsteadiness, confusion, blurred vision, slurred speech, nasal congestion and dryness, dry mouth, constipation.

Stimulants
Constipation, coughing, diarrhea, dizziness, drowsiness, dry mouth, flushing, headache, loss of appetite, nausea, nervousness, restlessness, stomach pain or upset, sweating, trouble sleeping, unpleasant taste, vomiting, weakness, weight loss.

Anti-Parkinson's Drugs
Dry mouth, constipation, blurry vision, slowed urination, excitation.

TERRENCE EARLY MD has explained to me that I have the right to accept or to refuse medication(s) recommended to me. I understand that if I have any further questions or want to know more about my medication(s), I can ask for more information.

Name	Signature	Date

AGREEMENT FOR RELEASE OF PRIVATE HEALTH INFORMATION

I, _____UNDERSTAND THAT AS PART OF MY HEALTH CARE, THIS PRACTICE ORIGINATES AND MAINTAINS HEALTH RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION AND TEST RESULTS, DIAGNOSES, TREATMENT, AND ANY PLANS FOR FUTURE CARE OR TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A BASIS FOR PLANNING MY CARE AND TREATMENT
- A MEANS OF COMMUNICATION AMONG THE MANY HEALTH PROFESSIONALS WHO CONTRIBUTE TO MY CARE; AND AS SUCH, A COPY OF MY PROVIDER'S NOTES AND/OR OTHER INFORMATION WILL BE SENT TO OTHER PROFESSIONALS TO WHOM I MAY BE REFERRED FOR DIAGNOSIS OR TREATMENT
- A SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND TREATMENT INFORMATION TO MY BILL.
- A MEANS BY WHICH A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED.
- A TOOL FOR ROUTINE HEALTH CARE OPERATIONS, SUCH AS ASSESSING QUALITY AND REVIEWING THE COMPETENCE OF HEALTH CARE PROFESSIONALS.

Please list persons (Spouse, Parent, Partner, Friend, Etc.) who are allowed access to your health records; Indicate type of access by adding the appropriate numbers (#) after the (name).

Please indicate all names and numbers consenting to:

	(Name)	(#) s (1, 2,3,4, or/and 5)
(1) Discuss appointments and scheduling		
(2) Discuss my Bill		
(3) Discuss Lab Results		
(4) Questions regarding treatment		
(5) Information regarding treatment		

TERRENCE EARLY MD AND INTERVENTIONAL PSYCHIATRY ASSOCIATES HAVE A PROFESSIONAL AND LEGAL OBLIGATION TO PRESERVE THE CONFIDENTIALITY OF PATIENT INFORMATION. AS A PROFESSIONAL HEALTH CARE FACILITY COLLECTING PERSONAL INFORMATION, TERRENCE EARLY MD AND INTERVENTIONAL PSYCHIATRY ASSOCIATES ENSURES THAT SUCH INFORMATION IS TREATED IN A CONFIDENTIAL MANNER TO PROTECT PATIENT'S RIGHT TO PRIVACY.

I UNDERSTAND AND HAVE BEEN PROVIDED WITH A NOTICE OF INFORMATION PRACTICES THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES. I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW THE NOTICE PRIOR TO SIGNING THIS CONSENT.

I UNDERSTAND THAT THE ORGANIZATION RESERVES THE RIGHT TO CHANGE ITS NOTICE AND PRACTICES AND, PRIOR TO IMPLEMENTATION, WILL MAIL A COPY OF ANY REVISED NOTICE TO THE ADDRESS I HAVE PROVIDED.

I UNDERSTAND THAT I HAVE THE RIGHT TO OBJECT TO THE USE OF MY HEALTH INFORMATION FOR DIRECTORY PURPOSES.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING, EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS TAKEN ACTION IN RELIANCE THEREON.

THE PATIENT OR FINANCIAL RESPONSIBLE PARTY ASSUMES FINANCIAL RESPONSIBILITY FOR ANY PORTION NOT COVERED BY YOUR INSURANCE COMPANY DUE TO OUT OF POCKET HEALTH EXPENSES, DEDUCTIBLE, OUT OF NETWORK, OR ANY OTHER "NON COVERED SERVICES".

A RELASE OF INFORMATION FORM MUST BE FILLED OUT, SIGNED AND DATED BY THE GUARDIAN/PATIENT BEFORE INFORMATION CAN BE RELEASED. WE CAN ONLY RELEASE INFORMATION FOR WHICH WE HAVE SIGNED CONSENT TO RELEASE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AND THAT THE ORGANIZATION IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED.

BY SIGNING BELOW I INDICATE THAT I FULLY UNDERSTAND AND ACCEPT THE TERMS OF THIS CONSENT

Name	Signature	Date

BY MY SIGNATURE, I AM GIVING TERRENCE EARLY MD AND INTERVENTIONAL PSYCHIATRY ASSOCIATES PERMISSION TO TREAT THE ABOVE REFERENCED PATIENT, AS WELL AS BILL PATIENTS, GAURANTORS AND FILE CLAIMS WITH APLICABLE INSURANCE COMPANIES.

CURRENT MEDICATION LIST

Name: _____ Date of Birth: _____

DRUG ALLERGIES:

CURRENT MEDICATIONS	DOSE	FREQUENCY

RECREATIONAL DRUGS	METHOD	FREQUENCY	LAST DATE USED

MEDICATIONS PREVIOUSLY TAKEN:

MEDICATION	REASON FOR STOPPING

Name _____ Signature _____ Date _____

I have reviewed the above information with the patient.

TERRENCE EARLY, M.D _____ Date

Any further information needed for treatment is reviewed with the doctor during the evaluation

ARE YOU CURRENTLY HAVING, OR HAVE YOU HAD PROBLEMS WITH: (CHECK ALL THAT APPLY)

General well-being

__ Fever
__ Weight loss (>10#)
__ Excess fatigue
__ Recurrent Nausea / vomit
__ Night sweats

Eyes

__ Wear glasses
Date of last exam _____
__ Glaucoma
__ Cataracts
__ Trouble focusing
__ Recent change in vision

Ears, Nose, Mouth and Throat

__ Wear hearing aids
Date of last exam_____
__ Hearing loss
__ Ear infection
__ Pressure in ears
__ Ringing in ears
__ Pain in ears
__ Itching in ears
__ Dizziness
__ Nasal congestion
__ Nasal drainage
__ Nosebleeds

Respiratory

__ Chronic cough
__ Emphysema
__ Bronchitis
__ Asthma
__ Chronic obstruction
__ Pulmonary disease
__ Oxygen use at home
__ Pneumonia
__ Lung cancer
__ Tuberculosis
__ Blood in saliva
Date of last chest X-ray____

Cardiovascular

__ Chest pain
Date of last EKG _____
__ Heart attack
__ High blood pressure
__ Low blood pressure
__ Irregular heartbeat
__ Heart murmur
__ Arm and leg swelling
__ High cholesterol

Gastrointestinal

__ Blood in vomit
__ Indigestion
__ Nausea / vomiting
__ Abdominal pain
__ Change in bowel habits
__ Ulcers or Gastritis
__ Hepatitis

Hematologic

__ Anemia
__ Hemophilia
__ Easy bleeding / bruising __ Swollen glands

Genitourinary

__ Urinary tract infection
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Kidney stones
__ Prostate cancer
__ Endometriosis
__ Uterine, ovarian or cervical cancer

Neurological

__ Disorientation
__ Fainting / blacking out
__ Light headedness
__ Seizures
__ Concentration problems
__ Speech problems
__ Muscle weakness
__ Coordination problems
__ Uncontrolled shaking
__ Headache
__ Migraine

Endocrine

__ Diabetes
__ Hormone problems
__ Low blood sugar
__ Thyroid disease
__ Increased appetite
__ Excessive urination
__ Temperature intolerance
__ Pituitary gland problems

Immunologic

__ Food allergies
__ Immune system problems
__ Frequent colds / infections

Skin

__ Dermatitis
__ Dry or scaling skin
__ Rashes
__ Changes in skin color
__ Changes in moles
__ Skin cancer
__ Breast pain or swelling
Date of last Mammogram
_____

Musculoskeletal

__ Broken bones
List:_____
__ Arm or leg weakness
__ Joint pain or swelling
__ Arthritis

Psychiatric

__ Anxiety
__ Depression
__ Manic/Depression
__ Schizophrenia
__ Considering suicide / homicide
__ Panic attacks
__ Sudden mood swings
__ Emotional difficulties
__ Insomnia
__ Other psychiatric problem

TERMINATION POLICY

A termination letter is based on the missed appointments or the patient's noncompliance. Office policy states that the patient is asked to find another provider after three missed appointments, failure to pay debt, noncompliance with treatment suggestions, and/or conduct issues that may be harmful to staff. Medication is provided during the transition based on refills already provided to the patient or the termination circumstances. We have provided referrals and/or you can refer to your insurance company for other physicians. Unfortunately, TERRENCE EARLY MD can no longer be the treating physician and can no longer schedule future visits once you have met the criteria for termination.

DR. JOHN CERVANTES
805-963-2918

SANTA BARBARA BEHAVORIAL HEALTH
805-681-0035

SANSUM CLINIC
805-681-7517

Name	Signature	Date

Please retain a copy of this for your records.