359 San Miguel Dr. Suite 210
Newport Beach, CA. 92660
Ph. (949) 642-7757
Fax (949) 682-7502

PATIENT INFORMATION

Date_____

Name (First)_____(Middle)_____(Last)_____

Date of Birth_____SS#_____Gender (M /F)_____

Driver's Lic #_____ Issuing State _____

Marital Status_____Height_____Weight_____

Home Address _____Apt.#_____

City_____State_____Zip_____

Phone (cell) _____(home)_____E mail_____

Employer Name _____Occupation _____

Employer Address_____

City_____State_____Zip_____

Primary Care Physician (PCP)_____Phone # _____

Therapist_____Phone #_____

Emergency Contact _____Relationship _____Phone #_____

Appointment Reminders via: (check all that apply) ☐ Text ☐ Email ☐ Phone call

Referred By: Physician, Therapist, Insurance, ER, Our Patient, Family, Friend, Search engine, Website?_____

Referring Person's Name:_____Phone #_____

Pharmacy Information:

_____

Name Address

_____

City State Zip Phone #

FINANCIAL INFORMATION

RESPONSIBLE PARTY **[ ] Myself** **[ ] Someone else**

If "Someone Else" then fill out the following: Your Relationship to the contact_____

Full Name_____
(First) (Middle) (Last)

Phone # (cell)_____(home)_____Email_____

Method of Payment: **[ ] Insurance** **[ ] Self Pay**

PRIMARY INSURANCE POLICY

Insurance Company_____Policy #_____

Insurance Plan Name_____Plan Code_____PPO/HMO/EPO?___

Group Name_____Group #_____

Relationship to Primary Policy Holder_____

Primary Policy Holder's Full Name_____
(First) (Middle) (Last)

Sex_____Date of Birth_____SS#_____

Policy ID #_____Address_____

City_____State_____Zip_____

SECONDARY INSURANCE POLICY

Insurance Company_____Policy #_____

Insurance Plan Name_____Plan Code_____PPO/HMO/EPO?___

Group Name_____Group #_____

Relationship to Secondary Policy Holder_____

Secondary Policy Holder's Full Name_____
(First) (Middle) (Last)

Sex_____Date of Birth_____SS#_____

Policy ID #_____Address_____

City_____State_____Zip_____

PSYCHIATRIC HISTORY

Patient Name_____DOB_____.

Chief Complaint_____

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ unmarried, committed relationship ☐ widowed ☐ other

Living Arrangement: ☐ alone ☐ with family ☐ with relatives ☐ foster care ☐ board & Care ☐ nursing home

Highest level of education completed? _____

When did you first notice any signs and symptoms related to this problem? _____

Circle the behaviors that apply to you:

Anxiety	Destroyed property	Avoid places/situations
Depression	Easily annoyed/irritated/ on edge	Anger
Impulsive act before thinking	Distressing dreams/nightmares	Disorganized thoughts
Suicidal thought (specify)	Memory Problems/changes	Sexual concerns
Physical abuse	Easily distracted/frustrated	Unusual perceptions
Sexual abuse	Difficulty paying attention	Paranoid/suspicious thoughts
Violent thoughts	Elevated or Hyper mood	Hallucinations
Too little or too much sleep	Increased activity level	Weight loss or weight gain
Excessive behaviors	Talking excessively	Racing thoughts
(ex: sex, gambling, shopping, computer)	Restless/agitated	Alcohol/drug problems
Poor appetite or over eating	Panic attacks	High –risk taking behaviors
Anorexia or binging/purging	Dizziness	Injuring or harming yourself
Feeling hopeless	Chest pain or shortness of breath	Relationship problems
Fatigue/ loss of energy	Numbness or tingling sensation	Family Problems
Feeling of worthlessness/guilt	Phobias or fears	Social support Problems
Difficulty concentrating	Fear of dying	Work/school problems
Difficulty making decisions	Obsessions or compulsions	Learning disabilities problems
Lost temper easily or exploded	Legal Problems	Withdrawing/ social isolation
Housing/economic problems	Hurting others(people/animals)	Started fight or argument
Hard to control worrying	Easily startled	Delusions

Comments/ other information:

_____

_____

Have these interfered with your ability to function? ☐ emotionally ☐ physically ☐at home ☐ at work or school

Explain how _____

_____

_____

Counseling/Psychiatric Treatment History:

	No	Yes	When	Provider Name/ location	For how long?
Counseling/ Psychiatric treatment	☐	☐	_____	_____	_____
Suicidal Thoughts/ attempts	☐	☐	_____	_____	_____
Hospitalizations	☐	☐	_____	_____	_____
Were you abused as a child?	☐	☐	_____	_____	_____

MEDICAL HISTORY

Circle all that apply to you:

AIDS/HIV+	Cancer	Hepatitis	Sexually-transmitted diseases
Alcoholism	Childhood diseases	Liver Problems	Allergies
Chronic Pain	High Blood Pressure	Tuberculosis	Anemia
Diabetes	Kidney Problems	Thyroid ProblemsArthritis	
Drug Abuse	Neurological Disorders	Vision Problems	Asthma
Epilepsy	Hearing Problems	Rheumatic Fever	Birth defects
Heart Problems	Stroke	Brain Injury	Headaches

Other (specify)_____

What medications are you taking presently? (Name, Dose) _____

_____

_____

_____

_____

_____

Do you have any known allergies to medication? ☐ No ☐Yes

(If so provide allergies and reactions to them) _____

_____

_____

Do you have history of Thyroid disease? ☐No ☐Yes

Do you have history of excessive hair loss/dry skin/feeling cold? ☐ No ☐Yes

Do you have any medical problems? (Describe) _____

_____

If any list past surgeries, hospitalizations, serious injuries and head injuries:

_____

_____

_____

FAMILY HISTORY

	Biological Family History	Adoptive/step/legal guardian medical history
Substance abuse	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Psychiatric Problems	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Had Thyroid Disease	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Abused Drugs or ETOH	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

SOCIAL HISTORY

Tobacco

☐ Current every day smoker ☐ Never smoked ☐ Current status unknown

☐ Current some day smoker ☐ Former smoker ☐ Unknown if ever smoked

☐ Light tobacco smoker ☐ Smoker

☐ Heavy tobacco smoker

Alcohol

☐ Do not drink ☐ Drink daily ☐ Frequently drink ☐ Hx of Alcoholism ☐ Occasional drink

Drug Abuse

☐INDU ☐ Illicit drug use ☐ No illicit drug use

Cardiovascular

☐ Eat healthy meals ☐ Regular exercise ☐ Take daily aspirin

Safety

☐ Household smoke detector ☐ Keep Firearms in home ☐ Wear Seatbelts

Sexual Activity

☐ Exposure to STI ☐ Homosexual encounters ☐ Not sexually active ☐ Safe sex practices ☐ Sexually active

Birth Gender

☐ Male ☐ Female ☐ Undifferentiated

MENTAL HEALTH DISCLOSURE FORMS

DEPRESSION SCREEN

Over the last 2 weeks, how often have you been bothered by any of the following problems	Not at All	Several Days	More than Half of the Days	Nearly Every Day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or hurting yourself in some way				

TWO QUESTIONS ABOUT YOURSELF

	YES	NO
During the past month, have you often been bothered by feeling down, depressed or hopeless?		
During the past month, have you been bothered by feeling little interest or pleasure in doing things?		

GENERALIZED ANXIETY DISORDER SCREEN

Over the last 2 weeks how often have you been bothered by the following problems?	**Not at All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
Feeling nervous, anxious or on edge				
Not been able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

MOOD QUESTIONNAIRE

Please check one box only for each of the questions below

1. Has there ever been a period of time when you were not your usual self and ……	**YES**	**NO**
….you felt good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?		
….you were so irritated that you shouted at other people or started fights or arguments?		
….you felt much more self confident than usual?		
….you got much less sleep than usual and found that you didn't really miss it?		
….you were much more talkative and /or spoke much faster than usual?		
….thoughts raced through your head and you could not slow your mind down?		
….you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
….you had much more energy than usual?		
….you were much more active and/or did many more things than usual		
….you were much more social or outgoing than usual for example, you telephoned friends in the middle of the night?		
….you were much more interested in sex than usual?		
….you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?		
….spending money got you or your family into trouble?		
2. If you have checked YES to more than one of the above, have you experienced several of these during the same period of time?		

3. How much of a problem did any of these situations cause you like being unable to work, having family, money or legal problems, and/or getting into serious arguments or fights?

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

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Credit Card Authorization

The undersigned agrees and authorizes Harbor Medical Associates, Inc. to save the credit card(s) indicated below on file. The use of this form is optional and for your convenience.

Patient's Name: _____

Patient's DOB: _____ _____

Type of Card: _____
(Master Card/Visa/AMEX/Discover/Debit Card/HSA Card)

Name as shown on the Card:_____

Card Number: _____

Expiration Date: _____(XX/XXXX) 2digit month/4 digit year)

CVV code: _____

Card Billing Address: _____

_____

I authorize Harbor Medical Associates, Inc. to process above credit card as "Card on File" and charge it for co-pays, co-insurance amount, deductibles, balance due and no-show fees that are patient responsibility. I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

☐ By checking this box, I acknowledge that I have read the company payment policies.

_____ _____
Cardholder's Name Cardholder's DOB

_____ _____
Cardholder's Signature Date

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LEGAL GUARDIAN/ REPRESENTATIVE'S AUTHORIZATION TO TREAT PATIENT

(if applies: **guardian/ representative needs to sign**)

Patient Information:

Full Name of _____
(First) (Middle) (Last)

Date of Birth_____SS#_____

Address_____

_____
City State Zip

Legal Guardian/ Representative's Information:

Full Name_____
(First) (Middle) (Last)

Date of Birth_____SS#_____

Driver's License #_____

Address:_____
City State Zip

I, _____am the Legal Guardian and/ or Legal Representative of the patient and on the patient's behalf I legally authorize Harbor Medical Associates, Inc.to deliver mental health care services to the patient. I also understand that all the Policies handed to me apply to the patient I represent.

_____

Legal Guardian/ Representative's Signature ***Date***

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AUTHORIZATION FOR THE RELEASE OF INFORMATION

Medical, Psychiatric and Substance Abuse Records

Patient Name (first)_____(Middle)_____(Last)_____

Date of Birth_____SS#_____

Address_____

City/State/Zip_____Phone _____

[ ] **RELEASE** my medical information **TO**: [ ] **OBTAIN** my medical information **FROM**

Name of Individual/Organization _____

Address:_____

_____

Relationship to Patient_____Phone #_____Fax #_____

Email Address_____

Rights & Restrictions: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of this authorization to be used and/or disclosed under this authorization in accordance with my organizational policy. Photocopy/Fax may be used as original. I understand I have the right to revoke this authorization in writing at any time or change what information is to be released. My revocation will be effective upon receipt but will not be effective to the extent that this organization has taken action in release upon this authorization.

Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code # 56.10(x) may not further disclose the medical information except in accordance with a new authorization or as specifically required or permitted by law.

I,_____(name of patient/or guardian), hereby authorize **HMA, Inc**. to disclose information and records obtained in the course of my diagnosis and treatment, and to receive information about My diagnosis and treatment for the following purpose: to obtain previous medical/psychiatric history, assist in diagnosis and treatment and to coordinate care on an ongoing basis with my other providers.

_____

Patient/Guardia's Signature *Date*

_____

Patient/Guardian, Name

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CONSENT FOR TREATMENT AND NOTICE OF POLICIES

I hereby consent and authorize Harbor Medical Associates, Inc. healthcare providers to perform diagnosis, medical treatment and psychotherapeutic interventions as may be indicated for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that thereupon I relieve my physician(s), medical staff, and the company, of all responsibility resulting from my action.

I also authorize Harbor Medical Associates, Inc., all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that might be required for processing of any of all claims for third party payors (including but not exclusive of, private insurance, Medi-Cal, Tricare, Work-Comp, etc.)

I acknowledge that I have been given the ability to review Harbor Medical Associates, Inc's policies including the Financial Policy.

PRESCRIPTION REFILL POLICY

Established patients are always given enough medication refills until the next office visit, so refills are not necessary over the phone. This is to limit medication errors and to protect your safety. If you have missed or cancelled an appointment, you will be provided with enough medication until the rescheduled visit, within 1-2 weeks of the missed appointment. You are responsible to notify the office at least 1 (one) week in advance if you are running out of your medication. If you have a mail-in service, they require a minimum of 2 (two) week notice to mail the medication to you on time. Medication refills are not emergencies and must be taken care of during your appointment and regular business hours Monday through Friday (9 am-5:00 pm).

FINANCIAL POLICY

We will submit claims to your insurance company for all medical services rendered at Harbor Medical Associates, Inc. It is **your** responsibility to verify that we are part of your insurance plan. We will attempt to verify your eligibility and benefits with your insurance carrier, however, this does not guarantee that they will pay for the services provided, and you will remain financially responsible if they do not provide payment.

Insurance Carrier or Policy changes -- If your insurance carrier or policy changes, please notify us immediately. We might not get reimbursed for services not authorized in advance by your new insurance company. You will be financially responsible for 100% of the billed charges if your insurance is terminated and you continue to receive services from this office and fail to notify us.

Self Pay (uninsured) – Payment is due in full at the time of service.

Legal Forms, Letters and Court Related Services -- If you need a simple letter or a short form filled out by the doctor, please ask the doctor to take care of it during your appointment. For more lengthy and time consuming forms there will be a fee based on the amount of time spent. Please do not wait until the last moment to take care of these forms. Give us at least 1-2 weeks to complete the paperwork. The fee for paperwork pertaining to Disability will be $100. (one-hundred dollar) Minimum charge for the Legal Reports is $200 (two-hundred dollar) but it could be more depending upon the time required. For other court related deposition, expert witness, etc. we can provide the fee details upon request.
Medical Records – all medical records requests are subject to a preparation fee. Any additional costs related to shipping and handling will be added to these costs (if applicable).

Divorce Related – the parent authorizing treatment for a child will be the parent responsible for the charges related to the care. If the divorce decree requires the other parent to pay all, or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Bad Debt—patients who do not pay bills within 90 (ninety) days of the statement date will be referred to collections agency, and ***may be discharged from the practice for non-payment.***

Missed Appointments or Appointments cancelled with Less than 24 hour advance notice—we reserve the right to charge $100 (one-hundred dollar) for each missed appointment and the appointment not cancelled at least 24 hours before the appointment time (Monday through Friday 9am-5:30 pm). This charge is not covered by your insurance. In case of 3 (three) No Shows or appointments cancelled with less than 24 hours of advance notice within a year, we reserve the right to discontinue further care.

Financial Responsibility—based on our contractual agreement with the insurance companies and our internal policies, we are informing you of the following:

- Your health insurance deductible and any expenses deemed not covered by your insurance company will be your financial responsibility.
- All monies owed by you, such as office visits co-payments and non-covered services, are due at the time of service.
- If you are not prepared to pay any amounts due at the time of visit, you will be asked to reschedule the appointment, unless the physician determines that your medical condition prohibits this.

Method of Payment – Our office accepts the following forms of payment: credit card, HAS card, Debit card, and check. A $35 (thirty-five dollar) service charge will be assessed to your account for any returned check by your bank. This charge is not covered by your insurance.

Thank you for understanding our policies. If you have any questions or concerns, please do not hesitate to contact our office at (949) 642-7757.

By signing in the box below indicates that you are acknowledging and are in agreement with all of the above. Further, you understand and agree that your consents/assignments remain in effect until you choose to revoke them in writing.

_____

(Signature of Patient or Authorized Representative) (Printed Name) (Date)

_____

(If signed Above by Representative, Relationship of signer to Patient) (Name of Patient if Different from Above)

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CONFIDENTIALITY POLICIES

Confidentiality is the legal right to privacy for all the patients who receive psychiatric services, Such as, all personal information presented to this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law. **However there are exceptions to confidentiality**. Please be advised, all information discussed in this office will remain confidential except under the following conditions set forth in this agreement:

- You consent in writing for Harbor Medical Associates, Inc. to release and disclose information.
- A breach of confidentiality is required or permitted by law. Examples include instances in which Harbor Medical Associates, Inc. have a reasonable suspicion of child abuse, elder/dependent adult abuse, danger to self and others, and other matters subject to law.
- Harbor Medical Associates, Inc. in their direction decide to obtain consultation on your case with a colleague or legal counsel, in which case no identifying information will be revealed.
- You fail to make regular payments on your outstanding bill, which can result in your bill being turned over to collection agency or submitted to small claims court.
- Upon notification of a social services agency case, wherein all information is shared with Harbor Medical Associates, Inc. will be conveyed to the assigned social worker and/or other SSA representatives and agents.
- If you are a party in litigation, including divorce litigation, and you tender your mental condition as an issue, your privilege may be waived. In custody cases you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluation. Harbor Medical Associates, Inc. may be required to produce your records and/or testify at deposition or trial if we are served with subpoenas or court orders. We can not give you legal advice as what actions may or may not waive your privilege.
- Please be aware that under California's Family Code, a parent without custody may still be entitled to information about his or her child's treatment.

A NOTE TO PARENTS ABOUT CHILDREN'S CONFIDENTIALITY

If a child participated in treatment, it is important to allow him/her to develop a Confidential relationship with his/her psychiatrist and/or therapist. As such, you understand that the most personal information that your child discusses with his/her therapist will not be ordinarily shared with you, Rather your child's doctor will provide you with general summaries of your child's progress without private details: you will of course have access to all medication information. The office is committed to informing you about unusual or dangerous symptoms of behaviors (such as violence, child abuse, self- abuse, suicidality, or intention to harm others, harm one self, drive while intoxicated etc).

By signing in the box below indicates that you are acknowledging and are in agreement with all of the above. Further, you understand and agree that your consents/assignments remain in effect until you choose to revoke them in writing.

(Signature of Patient or Authorized Representative)	(Printed Name)	(Date)
(If signed Above by Representative, Relationship of signer to Patient)	(Name of Patient if Different from Above)	

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INFORMED CONSENT FOR TELEMEDICINE SERVICES

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Sarabjit Sandhu, MD has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform *Sarabjit Sandhu, MD* of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of California and will be present in the state of California during all telehealth encounters with *Sarabjit Sandhu, MD*.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize Sarabjit Sandhu, MD to use telemedicine in the course of my diagnosis and treatment.

_____

(Signature of Patient or Authorized Representative) (Printed Name) (Date)

_____

(If signed Above by Representative, Relationship of signer to Patient) (Name of Patient if Different from Above)