JOY OF MEDICINE * RESILIENCY CONSULTATION
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Name_____ Today's Date _____

Date of Birth _____ Age _____ Gender _____ Race/Ethnicity_____

Religion_____ Marital Status _____ Who do you live with? _____

Address_____
Street City Zip
Home Phone: (____)_____ May I leave a message? Yes □ No □

Cell Phone: (____)_____ May I text re: scheduling? Yes □ No □

E-mail: _____ Permission to contact via email? Yes □ No□

Emergency contact: _____ Relationship to you_____

Emergency Contact's Phone: (____) _____

Medical Specialty_____ Position □ Physician □ Fellow □ Resident
Mode of Practice: □ Mercy Medical Group □ Sutter Medical Group □ Permanente Med Group
□ UC Davis Medical Group □ Woodland Medical Group □Government Employed
□ Independent Medical Group (4+ Physicians) □Independent Practice (1-3 Physicians)
□Federally Qualified Healthcare Center □Academic

SSVMS Joy of Medicine allows up to 6 no-cost consultations. Neither SSVMS, your employer, nor the CA Board of Medicine will be notified of your participation. Consultations will be tailored to your needs and goals, however SSVMS is not liable for payment to any third-party treatment provider if it is necessary to refer you for services outside of the program. My practice is regulated by the Board of Psychology, 1625 North Market Blvd, # N-215, Sacramento, CA 95834 and follows all applicable Federal and California laws. **Fees for additional consultations, late cancellations (less than 24 hours notice) or missed appointments are your responsibility at the rate of $175.** If you need urgent assistance, call CMA's 24-hour Physicians' and Dentists' Confidential Assistance Line at (650) 756-7787. This free service provides confidential doctor-to-doctor assistance and will not result in disciplinary action or referral to any disciplinary body.

My signature below indicates that I agree with, understand, and will abide by the terms above. I understand that I am financially responsible for missed or late cancelled appointments. I certify that I reside or work in Sacramento, El Dorado, Yolo, Placer, or Nevada county.

*Signature*_____ *Date*_____

*Printed Name*_____

HIPAA NOTICE OF PRIVACY PRACTICES

Private Health Information (PHI) constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care

I. HOW I WILL USE AND DISCLOSE YOUR PHI.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:
1. For treatment., 2. For health care operations. 3. To obtain payment for treatment, and 4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. (The following list is a compilation of federal and California laws)
When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement; If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority; If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency; If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations; To avoid harm; If disclosure is mandated by the California Child Abuse and Neglect Reporting law; If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims; For public health activities; For Workers' Compensation purposes. Appointment reminders and health related benefits or services; If an arbitrator or arbitration panel compels disclosure; I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-related benefits and services that may be of interest to you; If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law; If disclosure is otherwise specifically required by law.

II. RIGHTS YOU HAVE REGARDING YOUR PHI
You have the right to see, get copies of, or amend your PHI. You are entitled to file a complaint to the Secretary of the Dept of Health and Human Services, 200 Independence Ave SW, Washington, DC 20201. If you have any questions, please contact Lori Roberto, Ph.D. 601 University Ave, #222, Sacramento, CA.

I acknowledge receipt of this notice.

Name: _____ Date: _____ Signature: _____

Clinician Name:_____ Date:_____ Signature: _____