DAVID TAYLOR, M.D.

2730 WILSHIRE BLVD, SUITE 325
SANTA MONICA, CA 90403
(310) 943-9223

DIPLOMATE OF PSYCHIATRY, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY
DIPLOMATE OF ADDICTION MEDICINE, AMERICAN BOARD OF ADDICTION MEDICINE
DIPLOMATE OF FORENSIC PSYCHIATRY, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

Thank you for scheduling your appointment with Dr. Taylor.

Attached is the new patient paperwork to fill out and bring to your first session. A Release of Information consent form may also be completed if applicable. Contact information and a map to the office are attached as well.

Additional information about Dr. Taylor can be found online: www.DavidTaylorMD.com

I look forward to working together!

Sincerely,

David Taylor, M.D.
Assistant Clinical Professor, UCLA Department of Psychiatry and Biobehavioral Sciences
Diplomate of Psychiatry, American Board of Psychiatry and Neurology
Diplomate of Forensic Psychiatry, American Board of Psychiatry and Neurology
Diplomate of Addiction Medicine, American Board of Addiction Medicine
Qualified Medical Examiner, California Division of Workers Compensation

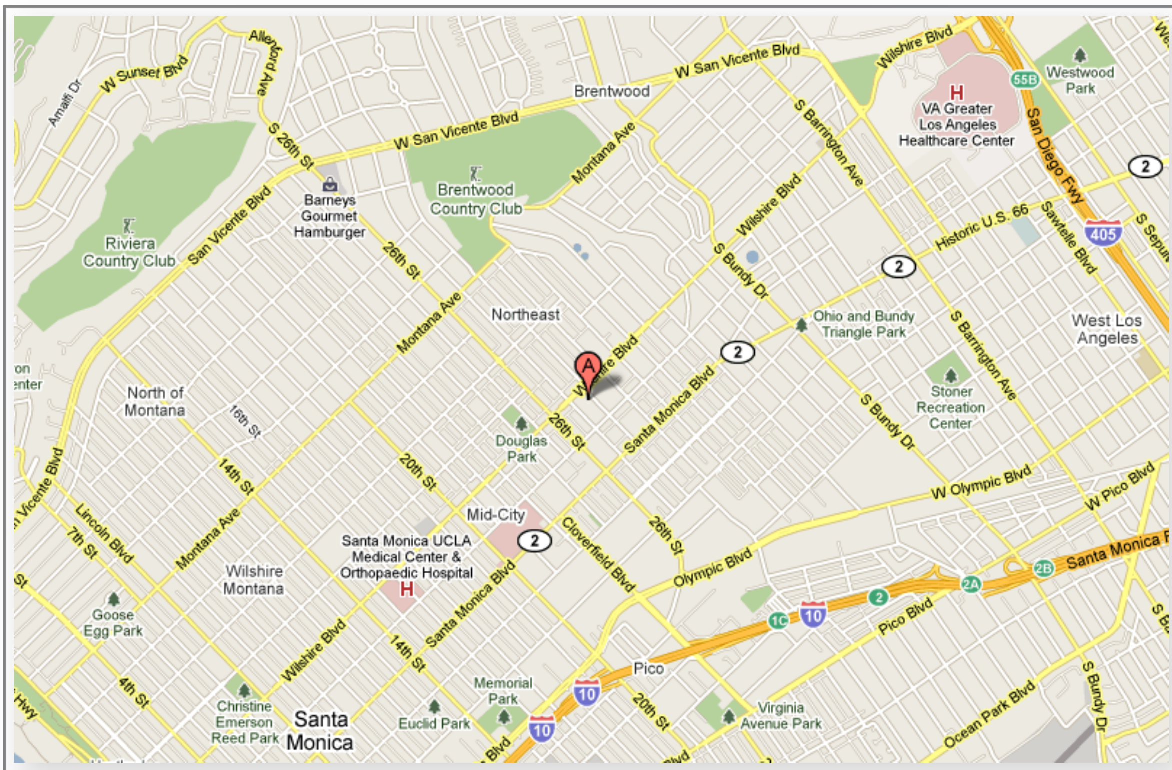
DAVID TAYLOR, M.D.

2730 Wilshire Blvd, Suite 325

Santa Monica, CA 90403

(310) 943-9223

(at the corner of Wilshire and Harvard, two blocks east of 26th Street)



Parking is available under the building or on nearby side streets.

www.DavidTaylorMD.com

Demographics

Contact information

Name ____

Birthdate ____

Address ____

____

Phone numbers (please indicate your preferred number)

Cell ____ ☐ OK to leave message?

Home ____ ☐ OK to leave message?

Work ____ ☐ OK to leave message?

Pharmacy information

Name ____

Phone ____

Emergency contact

Name ____

Relationship ____

Cell ____

Home ____

Work ____

Questionnaire

Background

Today's date ____

Referred by ____

Therapist ____

Primary care physician ______________________________

With whom do you live? ______________________________

Marital status ____

Occupation ____

Questions

1) Summarize briefly why you are seeking treatment at this time.

2) What symptoms or problems are most concerning?

3) When did you first notice the problem? How often does it occur?

4) Are you currently taking any medications (including over-the-counter or herbal supplements)?

5) Do you have any serious or chronic medical conditions (including past surgeries)?

6) Have you had any serious medical accidents, head injuries or seizures?

7) Have you had psychotherapy or psychiatric medications before? Hospitalizations?

8) Do you have any known medication allergies?

9) How much/often do you consume coffee or alcohol? Nicotine? Other substances?

10) Have you ever had any legal problems?

11) Is there a family history of mental illness, substance abuse or suicide?

12) Please indicate if you are/have experienced any of the following symptoms:

☐ Headaches	☐ Crying often	☐ Fears of losing self control
☐ Dizziness	☐ Unable to enjoy anything	☐ Unwanted thoughts
☐ Bowel trouble	☐ Restlessness	☐ Always worried
☐ Pain	☐ Decreased need for sleep	☐ Concentration problems
☐ Tremors or tics	☐ Mood swings	☐ Hearing voices
☐ Drug/alcohol cravings	☐ Excess energy	☐ Seeing things others do not
☐ Eating problems	☐ Confusion	☐ Strange experiences
☐ Binge eating	☐ Elated/euphoric mood	☐ Feel others are against you
☐ Sleep problems	☐ Excessive spending	☐ Constant suspicion/distrust
☐ Weight loss	☐ Racing thoughts	☐ Unusual thoughts
☐ Weight gain	☐ Irritability	☐ Violent behavior
☐ Loss of appetite	☐ Impulsive behavior	☐ Thoughts to harm others
☐ Feeling apart from others	☐ Grandiose thoughts/plans	☐ Physical abuse
☐ Low energy	☐ Anger/explosiveness	☐ Sexual abuse
☐ Feeling worthless	☐ Panic attacks	☐ Sexual problems
☐ Memory problems	☐ Anxiety	☐ Relationship problems
☐ Thoughts of suicide	☐ Fears	☐ Financial problems
☐ Feeling depressed	☐ Nightmares	☐ Work problems

Office Policies and Consents

Fees
- Payment is due at each session and may be made by cash or check.
- Credit cards are not accepted.

Insurance
- Dr. Taylor does not participate in any insurance panels.
- Some health insurance plans will reimburse a portion of fees paid for out-of-network service.
- Please consult with your insurance carrier in advance.

Canceled Appointments
- If you are unable to keep your appointment, kindly give 48 hours notice to avoid charges.

Missed Appointments
- Missed appointments are charged at the full rate.

Parking
- Underground parking is available for a fee. Metered street parking is available nearby.

Arrival
- Inside the waiting room, press the light next to the nameplate for David Taylor, M.D. to indicate your arrival.

Phone Messages
- Voicemail messages left during business hours will be returned promptly.
- Messages left on evenings, weekends and holidays will be returned the following business day.
- In the event of an emergency, proceed go to the nearest emergency room or call 911.

Email Messages
- Email communication is inherently non-confidential. By communicating with Dr. Taylor via email, you are accepting the inherent insecurity and the privacy risks therein.
- Email communication is not to be used for complicated medical matters, urgent issues or emergencies.
- All communication with Dr. Taylor will become part of your medical record.
- Email communication does not constitute legal notice to Dr. Taylor such as where notice is required by contract or any federal, state or local laws, rules or regulations.

Confidentiality
- The content of sessions is confidential except in certain situations including, but not limited to: cases where a patient may be a danger to self or others; cases of suspected child or elder abuse; cases where a patient may be incapable of taking care of him/herself; certain legal proceedings when required by a judicial subpoena.
- Medical records are separately maintained and are not released without your written authorization.

California Prescription Drug Monitoring Program (PDMP)

- Dr. Taylor routinely uses the State of California Department of Justice Prescription Drug Monitoring Program to access controlled substance prescription history.
- More information about the PDMP can be found online at https://pmp.doj.ca.gov/pdmp

Open Payments Database

- The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.
- The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at: https://openpaymentsdata.cms.gov

Medical Board of California

- Dr. Taylor is licensed and regulated by the Medical Board of California. It can be found at: www.mbc.ca.gov
- Medical licenses can be checked and complaints against the licensee can be made through the Board's website or by contacting the Board using the QR code here.

Acknowledgement of Independent Practitioner

- Dr. Taylor is an independent practitioner. Although other mental health professionals work in the office suite, Dr. Taylor is not in partnership with them and has no responsibility for their billing. He neither controls nor supervises the services they provide.

Acknowledgement of Receipt for 'Notice of Privacy Practices' (HIPAA)

- I acknowledge that I have received (paper or online version) the Notice of Privacy Practices and have been provided an opportunity to review it.

Signature

My signature below indicates that I have read the above office policies and consents, and agree to abide by these terms during my professional relationship with Dr. Taylor.

The undersigned patient or responsible party (parent, legal guardian) consents to and authorizes services by David Taylor, M.D. which may include evaluation, psychotherapy, medication treatment and laboratory tests.

The undersigned understands that he/she has the right to:

- Be informed of and participate in the selection of treatment modalities.
- Receive a copy of this consent.
- Withdraw this consent at any time.

Signature ____________________________ Date ______________________

Name ____________________________

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AUTHORIZATION TO RELEASE INFORMATION

I, ____________________________________, hereby authorize David Taylor M.D. to exchange information with and/or release copies of my psychiatric and medical record(s) pertaining to my treatment to:

____

NAME OF PERSON OR ORGANIZATION

____

ADDRESS OR PHONE

☐ All relevant and timely information may be released.

Only the following information may be released:

☐ Initial clinical summary
☐ Progress notes
☐ Medication records
☐ Laboratory results
☐ Substance abuse treatment
☐ Psychological testing
☐ Other ____

These records are required for the purpose of continuity of clinical care. This release will expire one year from the date signed unless otherwise noted.

I certify that I have read this form and that I understand its contents.

____ ________________________

PATIENT SIGNATURE DATE OF AUTHORIZATION