PNS | Pacific Neuropsychiatric Specialists

PATIENT INFORMATION

Please Select Treatment Office ☐ **Costa Mesa** ☐ **Huntington Beach** ☐ **Mission Viejo** ☐ **Orange** ☐ **Dana Point** ☒ **Anaheim**			Today's Date Date of Birth		
Last Name First Name MI			Gender	Marital Status	Age
Home Address City State Zip Code			Home Telephone Preferred ☐		
Employer/School	Employer/School Address		Work Telephone Preferred ☐		
Occupation	Social Security Number	#Driver´s License	Cellphone Number Preferred ☐		
E-mail Address		Preferred Pharmacy (Name & Phone)			
Address of Financially Responsible Person (Where to send billing statements)		Telephone Responsible Person Home: _____ Work: _____			
Primary Insurance	Name of Policy Holder and DOB	Policy Holder´s Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other			
ID Number	Group Number				
Secondary Insurance	#ID/Policy Number	Group Number			
Referred by Frend/Family Primary Doctor pnsoc.com Other: Insurance Hospital Yelp Therapist School Internet Search			Name of Referral Source		

Name of Primary Care MD/NP/PA	City_____ #Phone_____	Consent to Collaborate ☐ Yes ☐ No
Name of Current Therapist (if applicable)	City_____ #Phone_____	Consent to Collaborate ☐ Yes ☐ No
Name of Current Psychiatrist NP or PA	City_____ #Phone_____	Consent to Collaborate ☐ Yes ☐ No

X _____

Patient/Guardian Signature ***Date***

Pacific Neuropsychiatric Specialists

LATE CANCEL & NO-SHOW OFFICE POLICY: 24 BUSINESS HOURS

It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this, we must require you to be on time for your appointments. Late cancellations and No-shows (**including arriving more than 15 minutes late)** prevent scheduling of other patients who need access to medical care in a timely manner. Our clinicians will make every effort to also be on time, however *due to the nature of the practice and acuity of patient issues / symptoms, clinicians may run late on occasion*.

Once your appointment is scheduled, you will be expected to provide at least **24 business hours**' notice of cancellation. Business hours are considered 9am to 5pm Monday through Friday. This means that if you have an appointment on Monday you must cancel on Friday before the end of business to avoid being marked as a "no-show".

If you do not provide at least 24 business hours' notice, or fail to show for a scheduled appointment, you will be subject to being referred to seek another provider. Patients who "No-Show" ***three (3) times*** *within a 6-month time period will be discharged from the practice.*

We pride ourselves on offering the highest level of care that allows each patient the time needed to address their specific needs. Because of the focus of our practice and shortage of mental health providers, many of our clinicians have waiting lists and thus, no-shows or late cancels can take away from other patients seeking treatment. We understand that certain emergencies can arise that are beyond your control and we appreciate advanced notice when that happens. Please discuss any concerns with our staff in these circumstances.

I have read and understand the above-mentioned policies and will abide by these for services at Pacific Neuropsychiatric Specialists Inc.:

X _____

Patient / Guardian Signature *Date:*

PNS | Pacific Neuropsychiatric Specialists

EMERGENCY CONTACTS

IN CASE OF AN EMERGENCY ONLY, please list the individuals whom we may inform:

Name	#Phone	Relationship	Name	#Phone	Relationship

Patient / Guardian signature *Date:*

POLICIES & CONSENT FOR TREATMENT OF A MINOR (IF APPLICABLE)

Consent to Treat A Minor: Confidentiality in working with kids/ teens can be difficult for parents/ guardians to understand. Children / teens won't feel safe to open up in therapy unless they can be assured that what they say will be kept private. On the other hand, as a parent, you have a right to know how your child is progressing. In general, we will tell children that while we will be speaking with their parents from time to time, we won't share specifics of our work unless the child and clinician(s) have agreed beforehand. The exception is when information is obtained that falls under mandated reporter status (child/dependent/elder abuse) and/or knowledge that the child is suicidal or involved in any dangerous activities. In these cases, parents and the appropriate agencies (for abuse) will be notified. *In working with kids/ teens in therapy, the therapist/ child/ family are partners in the growth, but the therapist must serve as the guide while in treatment.* The frequency of parent meetings depends on the individual and is done periodically or as issues arise. In between sessions, you are welcome to email any concerns or updates to our clinicians with respect to the time it takes outside of the office to read these concerns/requests. Please use this mode of communication, including phone contact, to convey only the most important information and of course for any urgent issues.

OVERVIEW OF MEDICATION MANAGEMENT WITH KIDS/TEENS: Seeking psychiatric consultation can be an emotional and overwhelming process for parents. There is much to navigate when deciding whether medications are right for your child. Our Medical Specialists are very conservative with medications and will discuss all alternative treatments, the role of therapy, diet/exercise/ sleep needs, medical issues, etc. as part of a treatment plan. However, for many, medications are an essential element to treating symptoms and illnesses in mental health, just as in any other area of medicine. There can be a great deal of stigma surrounding mental health, as well as inaccurate information from friends or loved ones as well as in the media. Another challenge is that a majority of the medications needed to target certain biochemical pathways and areas of the brain are not FDA approved, but are the standard of care in the community and are used which *practicing evidence-based medicine* and psychopharmacology. You can be assured that you will work closely with our Medical Specialists collaborate on a plan that is best for your family.

We/I, the undersigned _____ *, parent(s) and/or guardian(s) of minor child* _____*, give you full authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me / us as a parent / guardian(s) of said child. We / I have legal power to consent to medical, psychological and mental health assessment and treatment of said minor child.*

X

Patient / Guardian signature *Date*

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PATIENT HEALTH HISTORY & QUESTIONNAIRE

Current symptoms/reason for seeking treatment:_____

Medical & Psychiatric History

Please list any current or past medical conditions/surgeries:_____

_____

Current Medications (with dosages):_____

_____

Current Vitamins/Herbs/Supplements/OTCs:_____

Names of any past psychiatric medications:_____

_____

Names of past Psychiatrists/Therapists:_____

History of Psychiatric Hospitalization (s)?_____History of Suicide Attempts/Self-Injury:_____

History of Depression Yes/ No Anxiety: Yes/ No Eating Disorders: Yes/ No Mania/Psychosis: Yes/ No Childhood history of mental health symptoms or academic difficulties?:_____

Last Physical Exam & Labs?:_____Allergies:_____Weight/Height:_____

Average # hours of sleep/night: _____ Avg # hours of exercise/week: _____ Balanced/Healthy Diet ◯ Yes ◯ No ◯ Unsure

Family history

List any family medical history (cancer, diabetes, thyroid, heart, etc:_____

_____

List any family psychiatric or addiction history:_____

Parents and siblings health status: _____

Social history

Relationship Status:_____ Names/Ages of Children (if applicable):_____

Length of current marriage/ relationship: _____ Any concerns with relationship?_____

Where did you grow up?_____ Do you have a history of abuse/ assault towards you of any kind? ◯ Yes ◯ No.

Parents and siblings (names/ages):_____

Please list any recent life changes/ stressful events/losses:_____

Substance history

Current alcohol, cigarette and caffeine use amount: _____

Current marijuana use? _____. Medical marijuana card? _____. Current use of other substances:_____

Past Substance Use/Treatment Centers?:_____

Sober Date (if applicable/in recovery):_____ Interested in treatment for smoking cessation?: ◯ Yes ◯ No ◯ N/A

X

Patient / Guardian Signature ***Date***

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OFFICE POLICIES & PROCEDURES

This is an agreement between Pacific Neuropsychiatric Specialists, Inc., the Patient named on this form.
By signing this form, you agree to pay for all services that are received and acknowledge understanding of all policies set forth hereto:

Confidentiality & Reporting: While one of the clinician's primary duties is to protect the patient's privacy and confidentiality, this duty is not absolute or without exceptions. Communications are confidential and generally no information will be released without your consent, except for the following: PNS, Inc. clinicians are considered mandatory reporters for child abuse and dependent adult / elder abuse. Clinicians may also have charts subpoenaed in legal cases however records may be subject to patient-therapist privilege and patient confidentiality / safety is utmost priority. Confidentiality is primary, however in the case of a threat to self or other harm, we must report.

Medical Records: Both law and the professional standards require that we keep appropriate treatment records. You are entitled to review a copy of the records, unless the clinician believes seeing them would be emotionally damaging, in which case, we will be happy to provide them to an appropriate mental health professional of your choice. Clinicians may have charts subpoenaed in legal cases however records are usually subject to patient-therapist privilege and will only be released with your consent or a court order. You must make your request in writing. *There is a fee for these copies*.

Emergencies: In the event of a psychiatric emergency, such as acute thoughts of harming oneself or others or a medically dangerous reaction to a medication, our staff can be reached through the urgent numbers specified on our office voicemail. If you are facing a true clinical emergency such as imminent danger to self or others, please call 911 or go to your local emergency room**.**

Insurance Policies: You are responsible for any amount that is not covered through insurance and charges rendered at times when your insurance is inactive. *It is the responsibility of the patient to fully check your benefits and coverage before your visit(s)*, although our office will assist patients in navigating benefits. If we are contracted with your insurance (in-network provider), we must follow our contract and their requirements. We will bill your insurance as a courtesy and after claims are received, the patient and office will receive an Explanation of Benefits (EOB) that reviews the charges and coverage. Due to the complexity of coding, you may see charges on your EOB for services or additional costs (i.e. patient education, consults, etc.). The amount due to the office is based only on the primary code billed. Please note as well that if you are choosing to use insurance for your visits, *the insurance carrier may request information such as diagnosis and copies of progress notes*. Many clients chose to not use their insurance for office visits because of this element. Please notify our office if you have any questions regarding this.

Medicare HMO risk Opt-Out Agreement: PNS, Inc. & affiliated clinicians are NOT accepting new Medicare HMO risk patients. By law, Medicare-eligible patients are required to enter into a private contract with PNS, Inc. and we deliver medical care on a on a fee-for-service basis, which is not reimbursable by the HMO contracted by Medicare. By accepting the treatment contract with PNS, Inc. you agree that you shall not submit a claim for payment under the HMO contracted by Medicare for services rendered at our office.

Payments: Unless other arrangements are approved by us in writing, the balance on your account is due and payable at the date it is requested in person or in wring by billing statement, whichever is sooner. Accounts are considered past due and delinquent / subject to reporting to collections if not paid within 90 days. *Any copays, office visits, or other costs must be paid at the time of service*. **Any copays or deductibles are an insurance requirement and cannot be waived or reduced by our office**. Please note there is also a *$25 fee for all returned check*.

Telephone Calls: We must screen all calls to the clinicians during office hours while they are seeing patients. Calls deemed "non- emergent" will be handled by the staff in the order received. If it is necessary to leave a message for the clinicians directly, calls *will be returned within 24-48 hours by either the clinician or staff, as appropriate*.

Prescription Refills: *Prescription refill request will be handled at the time of your appointment during regular business office hours*. Prescription refills will not be handled after regular office hours or on the weekend. It is your responsibility to monitor the amount of medication that you have available. PNS, Inc. will not refill prescription requests by phone or fax from yourself and or your pharmacy. PNS, Inc. medical staff will provide you with enough refills to last you until your next scheduled visit. We understand that there may be emergencies or situations beyond your control that necessitate emergency refills, if that is the case, you will need to come in to the office and request a refill in person, which will be given to you at that time. This is done to ensure your safety and to avoid misunderstandings with your pharmacy. If you do not have a follow-up appointment at that time, one will be scheduled for you. *Our clinicians reserve the right to deny refills* or reduce quantity / doses. Patient refills may also be denied if patients have not returned for follow-ups within the time frame agreed. *Furthermore, if accounts are past due and payments are not received, or a payment plan initiated, clinicians' refills will be granted once and at that point you will be responsible for any appropriate follow-up care*.

Changes in Address/Phone or Insurance: *Please notify us as soon as possible if you have any changes to your home or billing address, phone numbers and insurance coverage.* If we do not have current information this will delay payment and possibly cause you to have unexpected expenses. California insurance laws require claims to be filed no later than 90 days after the date of service and for some companies; the time frame is 30 days. Please also let us know if there are any concerns about the phone number used for reminder calls by our office. You will be asked to fill out a new information profile completely every year.

Legal Testimony: It is often unforeseen, but legal matters requiring the testimony of a mental health professional can and do arise. We offer Psychiatric Forensic Services. *If for any reason, you request, or we are subpoenaed on your behalf and required to testify or appear in court, you will be responsible for our court fees, which our office can provide upon request*.

Psychotherapy: Psychotherapy may have benefits such as significant reduction in distress, improved social relationships, resolution of specific problems, and clearer understanding of yourself, your values, and your goals. *For therapy to be most successful, you will have to be able to talk openly and honestly, address any difficulties that arise, and put forth active effort outside our sessions*. Our therapists have expertise in several areas of therapy and will collaborate with clients to create and individualized plan. Some therapy is brief, and some requires a longer duration to address symptoms and treatment goals. If you have any questions or uncertainties, please discuss them with your therapist.

Pharmacology / Medications: Medications management can be utilized alone or in conjunction with psychotherapy. If you are seeing medical specialists at PNS Inc. for medication management, we will work together to find the optimal combination of medication and therapy that help to fulfill your personal goals. When a medication is indicated, we will discuss with you the reason for the medication and the expectations or care and recovery, we will also discuss any reasonable alternative treatments. Further, you will understand the type(s) of medication being recommended; dosage and frequency and any possible side effects. As many conditions have an underlying biological basis, medications are an important component of treating psychiatric concerns. Please remember, you are dealing with a medical condition not a character flaw. Our aim is to *customize* a psycho-*pharmacological plan* specific to the unique needs and symptoms of the individual.

Laboratory Tests & Procedures: As part of your treatment plan, our Medical staff may recommend certain lab tests/blood work to be ordered to assist in diagnosis and rule out medical causes to symptoms. Our Medical staff is focused on comprehensive care for you. Certain medications also require routine and periodic blood work. We work with the latest technologies to provide you with optimal care and these incudes genetic testing to ascertain your body's ability to metabolize specific medications. Please make sure to discuss any physical symptoms, past medical history, etc. that may be important in your current situation. *If labs are ordered, it is your responsibility to make sure that lab services are included benefit in your insurance.*

Referrals/ Authorizations: *If your insurance requires a referral or pre-authorization, you are responsible for obtaining it*. Failure to do so may result in payment denials from your insurance. Occasionally our clinicians will refer you to another specialist. Recommendations are based on their experience with the specialist, but the specialist may/may not be an in-network provider with your insurance carrier. You will need to contact the office and/or your insurance to determine if that provider is covered.

Children & Pets: Children are very special to all of us and we are always happy to see them but for their safety and the courtesy of other patients we must ask that you keep your children with you always while in our office. Pets are not allowed in the office building, except animals that are registered therapy pets**.**

Cell Phones & Smoking / E-Cigarettes: Please refrain from talking on your cell phone and smoking / using electronic cigarettes while in the office or waiting area. This is distracting to others around you and to the environment that we hope to create within our office. Please be mindful that there are several professional businesses within this office building and thus respect their need for a quiet environment.

Grievance Policy: Communication is an essential element of your healthcare and interpersonal relationships. If at any time you have concerns, please discuss with your Doctor, NP, PA, therapist and/or our office manager. If a reasonable resolution has still not been achieved, you have the right to request a meeting with the Medical Director to discuss your concerns.

By signing below, I acknowledge that I have read the above office policies and procedures and I am consenting to treatment with PNS, Inc. and agree to abide any the terms during our professional relationship.

X

Patient / Guardian Signature ***Date***

PNS | Pacific Neuropsychiatric Specialists

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. *This is a* **SUMMARY** *of your rights and our responsibilities regarding your medical information and privacy. A full version of this Notice is available in our office, per your request. If you have any questions, please ask our Administrative Team. This information was last updated on September 23, 2013 and will remain in effect until replaced*.

Who: All clinicians and office staff at PNS, Inc. are committed to the privacy of medical information of our patients/ clients**.**

Protected Health Information (PHI): refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care.

How We May Use and Disclose Your Protected Health Information: In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule, we are permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, for health care operations, appointment reminders, treatment alternatives, health-related benefits and services, individuals involved in your care, worker's compensation, public health risks, as required by law, and to avert a serious threat to health of safety. For most uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization to Release Information.

2013 Omnibus HIPAA Final Rule (Update to HIPAA): New privacy standards were adopted in 2013 to further clarify and protect patients' health information/ confidentiality when it is disclosed but also to facilitate the flow of medical information between providers. Please read the following so that you understand your rights as a patient as well as the new rules about patient confidentiality. Feel free to ask about privacy, confidentiality, or psychiatric records. *Updates to previous HIPAA policies include the following*:
*Permission from the patient is no longer required for transfer of psychiatric and medical information between providers as long as only the necessary information is supplied. Collaboration of care agreements signed in the office can help to better specify this.
*Psychotherapy notes are not authorized to be release without patient consent and even if consent is obtained, our office often prefers to complete a treatment summary instead to protect your privacy and also better facilitate care.
*Substance abuse records from alcohol/ drug programs are exempt from any disclosure will outpatient permission. If you (or your child) are admitted to a treatment program for substance abuse be sure to sign a release so that we can talk to the providers and obtain a discharge summary and laboratory data upon discharge. Without this we cannot obtain any information.
*We may have to disclose some psychiatric information when required too so by law without your consent. This includes mandated reporting of child/ elder abuse and cases of legal order or subpoena (see confidentiality in Office Policies).
*National security and public health issues. We may be required to disclose certain information to military authorities or federal health officials if it is required for lawful intelligence, public health safety, or public security.

Patient Rights Regarding Your Protected Health Information (PHI) & Psychiatric Records:
*Right to Inspect and Copy your medical information: all patients have the right to inspect and copy their own protected health information (medical record) on request, except for mental health records, which must be reviewed with the clinician first. In cases where exposure to the record might be harmful to the patient, the clinician may deny the request. If you request a copy of your psychiatric record, we will generally review the record with you. It is unlikely that there would be information in the chart that a patient should not or could not read, but much of the information in the chart may require explanation.
*Right to Request an Amendment: of information you consider incorrect or incomplete.
*Right to an Accounting of Disclosures: that we have made of medical information about you.
*Right to Request Restrictions: or limitations on the information we use or disclose about you for treatment, payment, or health care.
*Right to Receive Confidential Communications: as specified by you and also by alternate means or locations.
*Right to a Paper Copy of This Notice.

Changes to the Notice: We reserve the right to change this Notice and will post a dated copy of in the office.
Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Office Manager or with the Department of Health and Human Services. You will not be penalized for filling a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of the summary of Notice of Privacy Practices and I am aware of my right to have a full copy of the entire HIPAA policy if desired.

X_____
Patient / Guardian Signature ***Date***

X_____
Witness Signature ***Date***

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AUTHORIZATION TO RELEASE INFORMATION

Medical, Psychiatric and Substance Abuse Records

Patient Name:_____ Date of Birth:_____ Today´s Date:_____

Address:_____#SSN:_____

City/State/Zip:_____ Phone:_____

CHECK ONE or BOTH: ☐ Please **OBTAIN** information **FROM**: ☐ Please **SEND** my medical information **TO**:

Name of Individual/Organization	*Address*	*Phone Number*	*Fax Number*	*Relationship to Patient*

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 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 reliance 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 that medical information except in accordance with a new authorization or as specifically require or permitted by law.

I,_____ (name of patient / or guardian), hereby authorize **PNS, 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.

X_____

Patient / Guardian Signature ***Date***

X_____

Witness Signature ***Date***

INFORMED CONSENT FORM
PSYCHIATRIC & PSYCHOTHERAPY

All practitioners are licensed in the State of California.

Although psychiatric and psychological services are helpful to most patients, there are no guarantees for success. Additionally, there are some risks in psychotherapy. Persons participation in therapy may experience strong emotions such as anxiety, frustration sadness, and anger when dealing with painful situations or unpleasant past events. Therapy may bring memories or realizations that may be distressing. People may experience unanticipated personal dilemmas, worries and or dreams. Thus, trying to resolve issues with important people in your life, such as spouse/partner, child, or other family members may result in changes that were not originally intended.

Medication interventions may have inherent risks associated with them. Although providers are fully qualified and highly skilled in prescribing medications, there is always a possible health risk when any medication is used. At the time a provider prescribes a medication, you will have a full explanation as to expected effect, risks, benefits and alternative treatments available to you or your loved one.

MEDICATION

Medications are often used as adjuncts to psychotherapy and group therapy. If a medication is indicated, we will discuss with you the nature of your illness, the reason for the medication, the likelihood of improving with or without medication. We will also explain any reasonable alternative treatment other than medication which have not been tried and an explanation why they should not be tried first.

The Doctor/Medical practitioner has discussed with me and/or my family the dose, ranges in dosing as well as the frequency in which the medication(s) should be taken. In addition, the Doctor/Medical practitioner has discussed with me and/or my family the possible side effects that particular medication(s) may cause, the dangers of taking the medication while under the influence of alcohol or other substances, including diet pills, and side effects that may occur relative to any medical problems I may have. Finally, the Doctor/Medical practitioner has discussed the effect of sudden withdrawal of the drug against medical advice.

I understand that I have the right to ask any questions about my medication(s) at any time during my treatment.

I also understand that this consent is valid for as long as I am under treatment and that I have the right to refuse my medication(s) at any time by calling the Doctor/Medical Practitioner to receive an appropriate medical review.

We have discussed risks, benefits and alternative treatments as well as non-pharmacological options associated with individualized treatment.
I have been given ample opportunity to ask any questions related to my treatment and I feel comfortable with the explanation given.

At this point full informed consent has been obtained.
I have read this form, understand it, and I consent to take the medication(s) prescribed by the Doctor/Medical Practitioner.

X_____ _____ _____
Patient's Signature Print Name Date

Member Rights and Responsibilities //

MEMBER RIGHTS

1. You have the right to receive information about Beacon's services, benefits, practitioners, providers, member rights and responsibilities and clinical guidelines. You have a right to receive this information in a manner and format that is understandable and appropriate to your condition.

2. You have the right to receive oral interpretation services free of charge for any materials in any language.

3. You have the right to be treated with respect as an individual in a manner that protects your privacy and dignity, regardless of race, gender, veteran status, religion, marital status, national origin, physical disabilities, mental disabilities, age, sexual orientation, or ancestry.

4. You have the right to have all communication regarding your health information kept confidential by Beacon staff and contracted providers and practitioners, to the extent required by law.

5. You have the right to participate with practitioners and providers in your own treatment planning and decision making regarding your care, and to include family members when appropriate and/or requested. Treatment planning discussions may include all appropriate and medically necessary treatment options, regardless of benefit design and/or cost implications.

6. You have the right to decide who will make medical decisions for you if you cannot make them.

7. You have the right to give or refuse consent for treatment and give or refuse consent for communication of treatment information to your PCP and/or other behavioral health providers.

8. You have the right to obtain information regarding your own treatment record with signed consent in a timely manner and have the right to request an amendment or correction be made to your medical records.

9. You have the right to appeal a Beacon Health Options authorization decision resulting in denial of any aspect of care or service.

10. You have the right to submit a complaint or concern (or have a designee do so on your behalf), verbally or in writing, about the care you have received.

11. You have the right to have questions or concerns answered completely and courteously by your providers and Beacon staff.

12. You have the right to contact Beacon's Office of Ombudsman to obtain a copy of Beacon's member rights and

responsibilities statement. You may make recommendations about the member rights and responsibilities statement to the Ombudsperson

13. You have the right to participate in the Member Advisory Council. You may make recommendations about the member rights and responsibilities statement to the council.

14. You have the right to exercise these rights without having your treatment adversely affected in any way.

15. You have the right to be free from restraint and seclusion as a means of coercion, discipline, convenience, or retaliation.

16. You have the right to access emergency care 24 hours a day, 7 days a week.

MEMBER RESPONSIBILITIES

1. You are responsible for choosing a primary care provider and site for the coordination of all your medical care.

2. You are responsible for carrying your HP/MCO member ID card and showing the card whenever you seek treatment.

3. You are responsible for understanding your benefits, what's covered and what's not covered.

4. You are responsible for understanding that you may be responsible for payment of services you receive that are not included in the Covered Services List for your coverage type.

5. You are responsible for providing information, to the best of your ability, to Beacon and treating providers that is necessary to ensure effective behavioral healthcare for you.

6. You are responsible, to the best of your ability, to understand your behavioral healthcare needs and participate in your treatment including developing, following and revising as necessary, mutually agreed upon treatment and aftercare plans.

7. You are responsible for contacting your Behavioral Health Provider, if you have one, if you are experiencing a mental health or substance abuse emergency.

_____ _____ _____

Member's Signature Print Name Date

PNS | Pacific Neuropsychiatric Specialists

TELEMEDICINE CONSENT

1) I understand that my health care provider wishes me to engage in a telemedicine consultation.

2) My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit since I will not be in the same room as my health care provider.

3) I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation

4) I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5) I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6) In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7) I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8) I have had a direct conversation with my doctor, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

PRINT NAME SIGNATURE DATE

PNS | Pacific Neuropsychiatric Specialists

PATIENT PORTAL REGISTRATION

NEXTGEN® HEALTHCARE Patient Portal

Pacific Neuropsychiatric Specialists is excited to offer a new feature-the Patient Portal! The patient portal is a convenient, secure, online tool available 24/7!

SIGN UP FOR THE PATIENT PORTAL TODAY!
Simply fill out your name, and email information below, and you will receive a link in the email you list below to complete registration for the Patient Portal!

Patient Name _____ DOB _____

Email _____

OTHER TREATMENT OPTIONS AVAILABLE TO YOU

Patients seen and evaluated at Pacific Neuropsychiatric Specialists are prescribed the most advanced medication interventions available in the United States. It is PNS' mandate to utilize psychopharmacology to the best advantage and for the highest well-being of our patients.
ATP Clinical Research and CPRI are the premiere clinical research organization in Orange County. ATP and CPRI have helped develop and works with new and novel medical compounds in clinical trials that may not be available to our patients in the open market.

ATP and CPRI offer clinical trials and investigational medication to you or your loved ones at no cost to you if you qualify for the study.

Most of the mental health medications that are now commercially available were available to our patients prior to having official FDA approval. If you or a loved one are interested in these novel medication trials, please be kind enough to sign the release of information below.

Authorization to share Psychiatric/Medical information with ATP Clinical Research, Inc. and California Pharmaceutical Research Institute.

I authorize Pacific Neuropsychiatric Specialists to discuss my treatment options with ATP Clinical Research Inc. and California Pharmaceutical Research Institute and give my consent for their staff to contact me, for treatment options that can be free at no cost to me; medication, lab work, office consultations, and diagnostic imaging, if I qualify for a study and participate.

_____ _____ _____

PRINT NAME SIGNATURE DATE