

LAGUNA BEHAVIORAL

28281 Crown Valley Parkway, Suite 140
Laguna Niguel, CA 92677

Phone: (949) 367-1200
Fax: (949) 367-1300

NEW PATIENT INFORMATION - ADULTS

CLIENT INFORMATION

Patient's Name: _____ Today's Date: _____

Other Names: _____

Date of Birth: _____ Age: _____

Address: _____

Street Apartment City State ZIP

E-mail Address: _____

May we contact you via e-mail () yes () no

PHONE NUMBER (S) Home () Work ()

May we call you/leave a message ...at home () yes () no ...at work () yes () no

on your cell: () yes () no

Marital status: () single () separated () divorced () widowed () living together () married

Employer/School: _____ Occupation: _____

Primary Care Physician: _____ Phone Number: () _____

WHO REFERRED YOU TO US?

() Friend () Health Plan/EAP () Family Member () Medical Doctor () Web/Other

INSURANCE INFORMATION

Health plan/ insurance _____ Policy ID # _____

Subscriber name _____ Subscriber social security _____

Employer _____

PERSON TO BE CONTACTED IN CASE OF AN EMERGENCY

Name _____ Home phone number () _____

Relationship _____ Work phone number () _____

Address if different from above:

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PRESENTING PROBLEM (S):

Please describe your reasons for seeking counseling:

Was there an event that made these issues or problems surface? **YES** **NO**
If yes please describe:

Please indicate which of the following issues or problems are you currently experiencing and would like to work on in treatment. You may choose more than one.

- | | | |
|---|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lack of friends | <input type="checkbox"/> Marriage/relationship problems |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Sexuality/sexual issue |
| <input type="checkbox"/> Controlling stress | <input type="checkbox"/> Problems coping | <input type="checkbox"/> Family conflict |
| <input type="checkbox"/> Loss of loved one | <input type="checkbox"/> Abuse/victimization | <input type="checkbox"/> Behavioral problems |
| <input type="checkbox"/> Problems at school | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Eliminating a drug/alcohol habit |
| <input type="checkbox"/> Problems at work | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Police/Probation Involvement |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Irritability | <input type="checkbox"/> Racing Thoughts |
| <input type="checkbox"/> Paranoid Thoughts | <input type="checkbox"/> Homicidal Thoughts | <input type="checkbox"/> Increased/Decreased Appetite |
| <input type="checkbox"/> Insomnia/Oversleep | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rages/Aggression |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Communication Issues |
| <input type="checkbox"/> Unable to Concentrate | <input type="checkbox"/> Discipline Issues | <input type="checkbox"/> Flashbacks |
| <input type="checkbox"/> Spending Sprees | <input type="checkbox"/> Hallucinations (Hearing/Seeing Things) | |
| <input type="checkbox"/> Eliminating another habit (overspending, overeating, gambling, etc.) | | |
| <input type="checkbox"/> Other: _____ | | |

(Please indicate)

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/school performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial situation	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety level/nerves	1	2	3	4	5	N/A
Food	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping habits	1	2	3	4	5	N/A
Sexual functioning	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control	1	2	3	4	5	N/A
Your temper	1	2	3	4	5	N/A

If you have any medical problems, please describe them below:

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Psychiatric History:

Have you seen a psychiatrist or therapist in the past? **YES** **NO**

Please list below

Have you ever been diagnosed with a psychiatric or mental health disorder? **YES** **NO**

Depression	Y N	Schizophrenia	Y N
Bipolar Disorder	Y N	Schizoaffective	Y N
Anxiety	Y N	Psychosis	Y N
Panic Attacks	Y N	Attention Deficit/Hyperactivity Disorder	Y N
Social Anxiety	Y N	Learning Disorder	Y N
Post traumatic	Y N		
Stress Disorder	Y N	Dementia	Y N
Anorexia	Y N	Pathological Gambling	Y N
Bulimia	Y N	Alcohol or drug abuse	Y N
Addictions of any kind	Y N		

Have you ever been hospitalized for mental health treatment? YES NO

If you indicated yes, please explain:

Please circle the psychiatric medication that you have taken in the past:

Buspar – buspirone	Ambien – zolpidem	Depakote – divalproex
Celexa – citalopram	Lunesta – eszopiclone	Lithium – eskalith
Cymbalta – duloxetine	Rozerem – ramelteon	Tegretol – carbamazepine
Effexor – venlafaxine	Desyrel – trazadone	Lamictal – lamotrigine
Lexapro – escitalopram		
Luvox – fluvoxamine	Valium – diazepam	
	Xanax – alprazolam	
Pristiq – Desvenlafaxine	Ativan – lorazepam	Abilify – aripiprazole
Paxil – paroxetine	Klonopin – clonazepam	Clozaril – clozapine
Prozac – fluoxetine		Geodon – ziprasidone
Remeron – mirtazapine	Vyvanse - Lisdexamfetamine	Risperdal – risperidone
Wellbutrin – bupropion	Ritalin - Methylphenidate	Seroquel – quetiapine
Zoloft – sertraline	Adderall - Amphetamine	Zyprexa – olanzapine
Elavil – amitriptyline	or Dextroamphetamine	Haldol – haloperaldol
Pamelor – nortriptyline		Trilafon – perphenazine

Please list any additional psychiatric medication that you have taken in the past:

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Family Psychiatric History and Medical History

Have any of your family members suffered from any of the above listed psychiatric disorders? Please explain:

Current or Chronic Illnesses:

Please list current medications and doses including over the counter medications and herbs and vitamins:

Allergies and reaction:

Have you ever abused drugs or alcohol before? **YES** **NO**

If yes, please describe:

<u>Substance</u>	<u>Amount</u>	<u>Frequency</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Have you ever received substance abuse treatment of any kind before? **YES** **NO**

Do you have a history of blackouts, seizures, or withdrawal symptoms? **YES** **NO**

Do you use tobacco products and if so how much? _____

How often and what kind of caffeinated beverages do you use? _____

How many beer, glasses of wine, mixed drinks, and shots do you typically have in an average week?

Have you ever felt that you need to cut down on your drinking? **YES** **NO**

Have people criticized your drinking? **YES** **NO**

Have you ever felt guilty about your drinking? **YES** **NO**

Have you ever felt a need to have a drink in the morning to steady your nerves? **YES** **NO**

Have you ever had a DUI? **YES** **NO**

Do you smoke marijuana or use any other drugs and how often? _____

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Are you currently involved in any legal problems? **YES** **NO** Please explain if answered yes:

Social History:

Where did you grow up and explain your family of origin (parents, siblings) and briefly describe your childhood:

Have you been a victim of abuse? **YES** **NO**

Current Living situation: _____

Do you feel safe in your current living situation? **YES** **NO** _____

Marital History and number and ages of children if applicable _____

Education and current employment _____

Current support systems _____

Please list any additional information that you think I should know or that you would like to discuss at today's visit.

What are your goals for psychiatric treatment?

OFFICE POLICIES AND AGREEMENT FOR GENERAL MENTAL HEALTH SERVICES

CONFIDENTIALITY

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It is understood that all information between client and psychiatrist(s) and/or therapist(s) is held strictly confidential, and the psychiatrist(s) and/or therapist(s) will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State laws;
2. The client presents an imminent danger to self,
3. The client presents an imminent danger to others;
4. Child/elder abuse/neglect is suspected;
5. If a judge determines that our discussions are not confidential, a judge may request specific information,
6. As requested by a court-appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the psychiatrist (s) and/or therapist (s) is required by law to inform potential victims and legal authorities so that protective measures can be taken. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a “no-secrets” policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family.

CONSENT FOR TREATMENT

I authorize and request that my psychiatrist(s) and/or therapist(s) at Laguna Behavioral/Adel Eldahmy, MD Inc. carry out psychiatric evaluations, psychological exams, treatments, and/or diagnostic procedures during the course of my care as a patient.

RELEASE OF INFORMATION

I authorize the release of information for claims, certification/case management, and other purposes related to the benefits of my health plan.

NOTICE OF PRIVACY PRACTICES

A notice of privacy practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA), describing how information about you may be used and disclosed and how you can get access to this information is provided to you. Please review it carefully. By signing below, you agree to the following: I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

I understand and agree to all of the above information.

Patient’s Name (printed)

Patient/Responsible Party’s Signature

Date

FINANCIAL TERMS

The fees for all services are negotiated between Laguna Behavioral/Adel Eldahmy, MD Inc. and your insurance carrier or managed care company. In general, you will not be asked to pay more than your co-pay/deductible as set in your insurance plan and explained in your insurance plan manual. In some cases you may request additional services not covered by your insurance plan.

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*At the time of service, if we are not able to verify and get full information regarding the patient’s insurance, he/she is responsible for the full contracted rate and will be given a receipt to submit to his/her insurance.

*With certain selected insurance companies the patient will be responsible for the full contracted rate and will be given a receipt to submit to his/her insurance.

Document copy services/medical record processing fees will be charged at \$30.00 per request and the patient will be responsible for \$35.00 charge per returned check.

All fees are to be paid at the time of service.

Certain health insurance plans have pre-arranged contracted fee arrangements that are different than the amounts quoted. Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for the visit and your provider will be paid directly by the carrier. **The patient will be responsible for any deductibles and co-payments at the time of service.** If you are not eligible at the time of services are rendered, you are responsible for payment or if your insurance carrier does not authorize the services, you are responsible for payment of the quoted fees or the rate negotiated with your insurance carrier, whichever applies.

REPORT WRITING

If required to write reports there is a minimum charge of \$50.00 for 1 page or less. Each additional page will be an extra \$50.00.

LITIGATION CHARGES

If I am required to attend a deposition, hearing or other legal proceeding you will be billed at \$300.00/hour for my time, which includes preparation and travel time, as well as the time I spend at the legal proceeding.

CANCELLATION/MISSED APPOINTMENTS

Scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than 24 hours notice, the patient will be billed \$100.00. This charge cannot be billed to your insurance plan.

Please sign to indicate that you have carefully read and agree to the above conditions.

Print Patient Name

Signature of Person Financially Responsible

Date