TO BE COMPLETED BY ALL *FIRST TIME* PSYCHIATRIC PATIENTS

Name: _____ **Date:** _____ **Age:** _____ **Sex:** _____
Insurance: _____ **Employed by:** _____
Ethnicity: _____ **Referred by:** _____
Marital Status: _____ **Therapist:** _____ **Phone #** _____

PRESENTING PROBLEM

Next to each item, please write the corresponding number and letter as follows:
0 = none 1 = mild 2 = moderate 3 = severe p = past c= current

PLEASE READ EACH SYMPTOM AND RATE ITS IMPACT:
0 = none
1= mild (impacts quality of life but not significant on functioning)
2 = moderate (significant impact on quality of life and functioning)
3 = severe (profound impact on quality of life and on day to day functioning)

#	L		#	L		#	L		#	L	
		Depression			Impaired Functioning			Parent/Teen Conflict			Death: _____
		Mania			Home			Family Conflict			Addiction:_____
		Anxiety			Social			Separation/Divorce			Behavior
		Psychosis			Self Care			Interpersonal Conflict			Fire Setting
		Dementia			Running Away			Loss			School/Work Avoidance
		Suicidal			Self Harm			Illness			Lying
		Homicidal			Harm to Others			Other:_____			Stealing
		Stress			Other:_____			Other:_____			Other:_____

SYMPTOM CHECK LIST

Next to each item, please write the corresponding number and letter as follows:
0 = none 1 = mild 2 = moderate 3 = severe p = past c= current

#	L		#	L		#	L		#	L		#	L	
		Depressed			Feel Shaky	Fears of:					Hear Voices			Confusion
		Irritable			Muscle Tension			Dying			See Things			Poor Attention
		No Interest			Restlessness			Losing Control			Surroundings seem 'unreal'			Poor Concentration
		Weight Loss			Short of Breath			Going Crazy			Homicidal Thoughts			Decreased Need
		Weight Gain			Racing Heart			Leaving Home			Others Out to Get Me			for Sleep
		Decreased Appetite			Sweaty Hands	Anxieties:					Unusual Beliefs			Pressured Speech
		Increased Appetite			Dry Mouth			Social Situations			'Others put thoughts			Mood Swings
		Decreased Sleep			Nausea			Phobias			in my head'			Racing Thoughts
		Increased Sleep			Diarrhea			Obsessive Thoughts			TV/Radio has special			Increase in
		Fatigue			Hot Flashes			Compulsive Behaviors			messages for me			Risky Behavior
		Feeling of Hopelessness			Lump in Throat						'I have special powers'			Excess Energy
		Feeling of Worthlessness			On Edge			Bed Wetting			Other: _____			
		Feeling Guilty			Easily Startled			Nightmares						
		Poor Self-Esteem			Mind Goes Blank			Night Terrors						
		Decreased Concentration			Dizzy									
		Suicidal Thoughts			Feel Unreal'									
		Crying Spells			Isolative									
		Decreased Sex Drive												

NATURE OF ILLNESS:
Character:_____
Length:_____
Prior Episodes: _____
Psychosis:_____
Mania:_____

PAST PSYCHIATRIC HISTORY

Describe ALL past mental health, drug, or alcohol treatment.
Include Inpatient, day hospital, support groups, family therapy,
martial therapy, counseling, individual therapy.
Start with the first date of treatment to present.

1)
2)
3)
4)
5)

PAST PSYCHIATRIC MEDICATIONS

Include dosages, dates takes, benefits, side effects	*Dates*	*Side Effects*
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

OTHER PSYCHIATRIC HISTORY

Describe any history of…

1. Suicide attempts: _____
2. Homicide attempts: _____
3. Self harm: _____
4. Harm to others: _____
5. Abuse to you: _____
6. Abuse by you: _____
7. Legal problems: _____
8. Eating Disorders: _____
9. Spiritual Issues of Concern (or for consideration): _____

Developmental delays: _____
Divorce/Separation: _____
Military History: _____
Family Psychiatric/Chemical Abuse History: _____
_____
_____
_____
_____

SUBSTANCE USE HISTORY

Describe all use of alcohol/drugs (alcohol, amphetamines, cannabis, cocaine, sedatives, hypnotics, anxiolytics, opium, hallucinogens, PCP, inhalants, cigarettes/nicotine, etc.)

SUBSTANCE	FIRST USE	LAST USE	AMOUNT/ FREQUENCY (past month)	PERIOD OF PEAK USE	LONGEST ABSTINENCE (WITH DATES)	RESULTING PROBLEMS: (DUI's, blackouts, seizures, DT's, loss of job, health, relationships, arrests, etc.)
1)						
2)						
3)						
4)						
5)						

CURRENT/PAST MEDICAL PROBLEMS *CURRENT MEDICATIONS* ***(Prescriptions, over-the-counter, etc.)***

1)	Medication	Dosage	Date Started
2)	1)		
3)	2)		
4)	3)		
5)	4)		
6)	5)		

OTHER MEDICAL HISTORY

List medication allergies:	
Date/results of last physical/lab work:	
Date/results of any prior MRI/CT scans of the head:	
Date/results of psychological testing:	
Prior history of head trauma, seizures, loss of consciousness:	

Pregnant? ☐ Yes ☐ No If no... ☐ abstinent ☐ birth control ☐ hysterectomy, tubal ligation ☐ on period ☐ menopausal

Family History of Physical Health Problems:

Patient's Information Form

Patient's Name:		**DOB:**
Address:		**Sex:** M or F
		Social Security Number:
Phone Number:	**Phone Number:**	

(below is for office use only)

Date of Service	Procedure Code	Diagnosis Code	Charges	Payment

Policies and Procedures

Confidentiality - I understand that all information shared between my psychiatrist and myself is held strictly confidential unless:

1. I authorize a release of information with my signature.
2. I present a danger to myself.
3. I present a danger to others.
4. Child/elder abuse or neglect is suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities.

Release of Information - In addition to releases of information permitted above, I authorize discussion of my case with the referral source and my other healthcare providers and facilities for the purpose of diagnosis and treatment. I further authorize the release of information for claims, certification, case facilitation, quality improvement, and other purposes related to the benefits of my health plan to my insurance carrier(s). Initial: _____

Financial Terms - If there is insurance, I will be responsible for any deductibles, co-payments, or coinsurances at the time of service. If I am not eligible for any reason at the time services are rendered, I will be 100% responsible for payment. Payments for services not covered by insurance are due at the time of service. If I am without coverage, payment arrangements will be made prior to my first visit. If I become over 90 days delinquent in payment, I understand that my account and the breakdown of charges may be sent to a collection agency.

Initial: _____

Canceled/Missed Appointments - A scheduled appointment means that time is reserved for me. I will call Dr. Di Bella (or leave a message) 24 hours prior to a scheduled appointment if I need to cancel. I am responsible for my appointment time. I understand and agree that I will be charged a fee of $45 for my missed medication follow-up session if I cancel late or do not show up at the scheduled time and that my insurance provider does not cover no show or late cancellation fees.

Initial: _____

Grievances - I acknowledge that I may submit a Grievance to Dr. Di Bella at any time to register a complaint about any aspect of my care. If I am not satisfied with the response I receive, I may submit the Grievance to my insurance company directly. I may also contact the California Department of Managed Care and use the appeals and grievance process at (800)400-0815.

Emergency Procedures - If I need to contact Dr. Di Bella after regular business hours, I will call (714)520-9759 and follow the voice mail instructions. I have the option to contact Dr. Di Bella directly if it is a true emergency. I understand there is a charge for telephone consultations.

Consent for Treatment - I further authorize and request that Dr. Di Bella carry out psychological examinations, treatments, and/or diagnostic procedures which are advisable during the course of my care. I understand that the purpose of these procedures will be explained to me upon my request and will be subject to my agreement.

Solution-Focused Therapy - My insurance plan usually pays for treatment using solution-focused philosophy. This treatment is goal oriented, problem focused and based on realistic, measurable objectives. Treatment emphasizes the reduction of symptoms that are causing distress and an impairment of social and/or occupational functioning. I understand that the insurance company expects that I am collaborating in the process of goal setting, homework assignments, and skill development.

I understand and agree to all of the above information.

Patient or Legal Guardian Signature:_____ Date: ____/____/____

Printed Name: _____

Prior Authorization and Uncovered Services

I, the undersigned, understand that behavioral health treatment is a specialty service and often requires a prior authorization from my insurance provider or a referral from my primary care physician. I acknowledge it is ultimately my responsibility to understand my specific benefit plan with my insurance provider.

I understand that any dispute of co-pay and/or deductible amounts is between me and my insurance company.

I understand that Dr. Di Bella does not accept all insurance companies; if I switch to an insurance company that Dr. Di Bella does not accept, I will be responsible for the full rate for my visit and my new insurance will not be billed or I will be responsible for any reduced out of network benefits that may be available.

I understand that my insurance company often does not cover certain services: i.e., telephone calls to consult with my psychiatrist, reports to be completed by my clinician at my request (such as disability forms), or refills requested over the phone. If I wish to avail myself of these services, I agree to pay the charges.

If I change insurance companies, insurance eligibility, contact phone numbers, and/or my address at any time, I agree to inform Dr. Di Bella right away.

Signature (*patient/ legal guardian*): _____Date: ____/____/____

Notice of Privacy Practices

Our office will provide you with a personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it.

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

We ask that you sign and return this to us for our records. Your signature only acknowledges we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining your signature.

Signature (*patient/legal guardian*): _____Date: ____/____/____

Notice of Privacy Practices

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI) for certain treatment, payment and health care operations purpose without your authorization. In certain circumstances, we can only do so when the person or business requesting your PHI gives us a written request that includes certain promises regarding protecting the confidentiality of our PHI. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment" is when we or another healthcare provider diagnoses or treats you. For example, when we consult with another health care provider, such as your family physician or a psychologist regarding your treatment
- "Payment" is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Healthcare operations" is when we disclose your PHI to your healthcare service plan (for example your health insurer), or to your other healthcare providers contracting with your plan for administering the plan, such as case management or care coordination.
- "Use" applies only to activities within the business such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- "Disclosure" applies to activities outside of the practice group, such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" means written permission for specific uses or disclosures.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment and payment operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychiatric progress notes or medical records of your sessions.

You may revoke or modify all such authorizations (of PHI or psychiatric progress notes) at any time; however, the revocation or modification is not effective until we receive it.

Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: Whenever your psychiatrist has knowledge of or observes a child they know or reasonably suspects has been the victim of child abuse or neglect, they must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if your mental health provider has knowledge of or reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, they may report such to the above agencies.
- Adult or Domestic Abuse: If your psychiatrist has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, or if they are told by an elder or dependent adult that he or she has experienced these, or if your psychiatrist reasonably suspects such, they must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.
    - Your psychiatrist does not have to report such an incident if:

- They have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;
- They are not aware of any independent evidence that corroborates the statement that the abuse has occurred;
- the elder and dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia;
AND
- In the exercise of clinical judgment, your psychiatrist reasonably believes that the abuse did not occur.

- Health Oversight: If a complaint is filed against your psychiatrist with the appropriate licensing board, that board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made about the professional services that your psychiatrist has provided you, we must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. We will inform you in advance if this is the case.
- Serious Threat to Health or Safety: If you communicate to your psychiatrist a serious threat of physical violence against an identifiable victim, they must make reasonable efforts to communicate that information to the potential victim and the police. If your therapist or psychiatrist has reasonable cause to believe that you are in such a condition as to be dangerous to yourself or others, they may release relevant information as necessary to prevent the threatened danger.
- Worker's Compensation: If you file a worker's compensation claim, we must furnish a report to your employer incorporating findings about your injury and treatment within five working days from the date of your initial examination and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

Complaints

If you are concerned that we have violated your privacy rights or your disagree with a decision we have made about access to your records you may contact us. You may also send a written complaint to the Secretary of the US Department of Health and Human Services.

Changes to Privacy Policy

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice either in person or by mail.

Health Care Coordination

Consent for release of confidential information to primary care physician or other provider

Patient Name: _____ DOB: _____/_____/_____
SSN: _____-___-_____

I hereby authorize release of the medical information pertaining to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment in written or verbal form to my primary care physician or other provider:

Primary Care Physician: _____
Address: _____
_____
Phone:(___)___-_____ Fax:(___)___-____
Faxed/Mailed:_____

Therapist/Counselor: _____
Address: _____
_____
Phone:(___)___-____ Fax:(___)___-____
Faxed/Mailed:_____

Other Provider: _____
Address: _____
_____
Phone:(___)___-_____ Fax:(___)___-____
Faxed/Mailed:_____

Other Provider: _____
Address: _____
_____
Phone:(___)___-____ Fax:(___)___-____
Faxed/Mailed:_____

I understand that the release of this information is to facilitate my primary care givers monitoring my health and to coordinate all the care which I may receive from specialists. This authorization becomes effective on the date signed. I understand that the information authorized by this release will be provided to the authorized recipients only.

Signature (*patient or legal guardian*): _____ Date: ____/____/____

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*This is **NOT** a request for records! This is a patient release for communication between psychiatrist and other providers regarding a mutual patient's care.*

Dear Colleague:
In order to coordinate care, I wish to inform you that your patient:
Name: _____ DOB: _____/_____/_____
was first seen at my office on: ____/____/____
The DSM-IV diagnosis/code is: _____

Outpatient care is being delivered, and the treatment plan consists of the following recommended modalities:
[ ] Individual Psychotherapy [ ] Family Psychotherapy [ ] Group Psychotherapy
[ ] Medication Management [ ] Other ( )

The following medication(s) are being managed by Dr. Geoffrey Di Bella, MD:
Medications and Dosages:
1. 2.
3. 4.
5. 6.
If you need additional information or suggestions, please contact me.

Geoffrey Di Bella, M.D.
1400 Quail St, Suite 150 Phone: (714) 520-9759
Newport Beach, CA 92660 Fax: (949) 442-1664