Playa Vista Mental Health

12057 Jefferson Blvd LA, CA 90230

Please read and complete each of the sections listed below as completely as possible.

DIETITIAN NUTRITIONIST INTAKE FORMS

- Name (First, Middle, Last): ____
- Have you ever gone by any other name? If yes, please specify: ____
- Date of birth: ____________ Sex: M / F Marital Status: __________________
- Street Address: ____________________________

  City: _________________ State: ______ Zip: ______________________
- Email address: ______________________________
- Occupation: ____
- Phone Numbers (Please check the box if able to leave a detailed message):

  ☐ Home: _______________ ☐ Work: ______________ ☐ Cell: ____________________

Medical and Referral Information

Name of Primary Care Physician: ____

Telephone Number of Primary Care Physician: ____

Address of Primary Care Physician: ____

May I contact your health care provider in the future? Yes No

Who referred you to our practice? ____

Please list names and contact information for any doctors, therapists and/or dietitians that have been significantly involved in your care over the last ten years.

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____

Emergency Contact

Who should we contact in case of emergency?______________________________________

Relationship to you? _________________ Phone number _______________________

Medical History

Chronic medical problems (diabetes, hypertension, heart disease, etc.):____________________________

____

Mental health conditions: ____

Family Medical/Mental Health/Drug/Alcohol History (siblings, parents, children, aunts/uncles):

____

____

____

Current medications (name/dosage/frequency/reason for taking the medication):

____

____

____

Allergies: ____

Supplements, vitamins, or herbs: ____

Drug or alcohol use (include amount and frequency): ____

____

Do you currently use tobacco: Yes No If yes, how long? _________________________________

Have you ever used tobacco in the past? Yes No If yes, please specify: _______________

Reason for coming in: ____

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Authorization to Release Patient Health Information for

Treatment, Billing, or Healthcare Operations

I understand that Playa Vista Mental Health reserves the right to change their notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing. I understand that the Playa Vista Mental Health staff are not required to adhere to these restrictions requested in the event of a potentially life threatening emergency.

Records may be needed in order to process a claim for services. I authorize providers at Playa Vista Mental Health to release information needed for billing purposes to entities that may provide services pertaining to my visit. I understand that by signing below, I am authorizing the release of all or part of my record for the purpose of billing, treatment, or pertinent healthcare operations.

Patient/Guardian Signature____ Date_____________

Patient/Guardian Printed Name____

I authorize Playa Vista Mental Health to discuss my health care to any and all past or present treating health professionals as well as the following (*please list* any friends or family members that you may want to have included in your treatment):

____

I am aware that this information may pertain to my health condition and/or treatment of substance abuse. I execute the release of this information.

Patient/Guardian Signature____ Date_____________

Patient/Guardian Printed Name____

Agreement for Service / Informed Consent

This agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Dietitian for _________________________ (herein “Client”) and is intended to provide important information regarding practices, policies and procedures of Dietitian, and to clarify the terms of the professional relationship between Dietitian and Client.

Privacy and Release of Information

The information disclosed by the Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law listed below:

- Threats of harm to yourself of others
- Abuse of a vulnerable adult, child, or developmentally disabled person
- A court order to release information
- Subpoena of treatment records by an attorney. If you do not want this information released, you must obtain a protective order from the court within fourteen days of the request.
- If you will be submitting a claim to your health insurance, we may be required to prove information to your health plan, including some or all of your record of treatment, in order for your carrier to pay for services. By signing this form, you consent to release this information to your health plan.
- If you are involved in a child custody litigation at any time in the future, the court may order release of information about your treatment

In circumstances other than these, I will not release information about your treatment without your authorization.

Notice of Office Policies and Procedures

Patient Records

A secured electronic record is kept of services you receive in this office. You have the right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize, in writing, that copies of the record be released to entities you designate. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider.

Methods of Communication and Execution of Clinical Care

You can generally expect a return call within two business days that a message is left. Should there be an emergency or concern for imminent health or the safety of yourself or another person, please call 911 or go to the nearest emergency room immediately.

Hospitalization

Should you require hospitalization, please go to your nearest emergency room or dial 911. Staff at Playa Vista Mental Health do not have admitting privileges at the hospital. Should you need to be admitted, they can communicate with the inpatient treatment team to let them know about your prior treatment.

Consent for Additional Services

Consent for Video Conferencing:

Providers can use video conferencing to see clients, should that be the best option for the dietitian and client. Please keep in mind that this is up to the discretion of the provider. Should the client elect to use video conference services, please note that there will be a $20 fee that will be added to the bill for related expenses incurred by use of the service. Also, please note that if you plan to submit your superbill to your insurance company for reimbursement, they may not reimburse as much as they would if you were seen in the office.

Patient/Guardian Signature____ Date_____________

Patient/Guardian Printed Name____

Consent for Secure Messaging:
Patients are offered the opportunity to use secure messaging (similar to email) with providers through patient fusion. Should a patient elect to do this, please keep in mind that this service should only be used for non-emergent matters as messages are not checked daily. This service is HIPAA compliant.

Should there be an emergency, the best option is call 911 or go to the nearest emergency room.

Patient/Guardian Signature____ Date_____________

Patient/Guardian Printed Name____

Consent for Email and/ or Text Messages

I understand that Playa Vista Mental Health cannot guarantee the confidentiality of any email communications and will not be liable for improper disclosure of confidential information and/or breaches in confidentially caused by me or a third party. I understand that Playa Vista Mental Health has no control over the security or management of my individual email service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient. I further understand and agree that: email will not be used in emergencies and I agree to call 911 in the event of an emergency, emails will be answered within a maximum of 7 business days and that a prompt reply may not be available during weekends or holidays, I must include my full name and date of birth in every email message I send, I understand and agree that providers may choose to stop electronic communications with me at any time, and I understand that the confidentiality of my individually identifiable health information may be compromised when such is sent through email. I agree to the requirements listed above and hereby voluntarily request and consent to communicate with dietitian and/or office personnel by email or text.

Patient/Guardian Signature____ Date_____________

Patient/Guardian Printed Name____

Insurance Benefits and Patient Responsibilities for Fees

We do not participate as a contracted provider for any insurance company, but can provide you with a detailed receipt called a superbill that you may submit to your insurance company. They may or may not provide some direct reimbursement to you. Payment is due at the time the service is rendered. Fees are reevaluated annually and may increase by up to 5% per year. We accept cash, check, and major credit cards. It is required that a credit card be kept on file. This card will be charged the **full fee for failure to keep any scheduled appointments without 24 hours prior notification** (or **one business day**- so in the case of weekends and holidays, cancellations will need to be made more than 24 hours in advance) and will also be used when billing for phone calls. Phone calls longer than ten minutes may be charged as a full session. Any outstanding fees will be charged to the card designated on this form.

Fee Agreement

CPT	DESCRIPTION OF PROCEDURE	MINUTES	FEE
97802	Initial Evaluation	80	$275
97803	Dietitian Follow Up	50	$180
97803	Dietitian Follow Up, Condensed	25	$90

Forms/letters: $50-$200 (Variable/time dependent) Insufficient funds/returned check fee: $50

I understand and accept the terms of the charges, cancellation fees, insufficient funds/ returned check fees and no-show policy as outlined above and authorize Playa Vista Mental Health (or Dr. Deborah Fein Medical Corp) to charge my credit card or checking account accordingly.

Name on Card:___________________________________

Card #____

Expiration date: ________________ Security code: _____________

OR

Name on account: ____

Account#: _______________________________ Routing#: _________________________

Phone number associated with account: ____________________________________

Billing street address:____

City: __________________ State: ___________ Zip:_____________

Signature: _____________________________________ Date: __________________

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as the medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided aby California law, and not by a lawsuit or resort to court process except up as California law provides for judicial review of arbitration proceedings. Both parties to this contact, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liabilities and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________________
Physician's or Duly Authorized Representative Signature (Date)

By ______________________________
Print or Stamp Name of Physician, Medical Group or Association Name

By: ______________________________
Signature of Translator (if applicable) (Date)

____
Print Name of Translator

By: ______________________________
Patient's Signature (Date)

____
Print Patient's Name

By: ______________________________
Patient's Representative's Signature (if applicable)(Date)

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Print Name and Relationship to Patient