CI MA. M. D. INC

Adult Psychiatry and Addiction Medicine

7850 Vista Hill Ave, San Diego, CA 92123

(858) 848-5386 Fax (234) 230-3665

Name_____ Birthday ___-____-____ Sex:

Home phone (_____)_____

Address (including Zip code)

_____

_____

E-mail address _____

Cell Phone (_____)_____

Occupation/Employer_____

Emergency Contact (name, relationship, Phone)

_____

_____

Pharmacy if known (including name/zip code)

_____

_____

Primary physician_____

Referring Physician/Psychologist/Therapist:

Signature_____

Date_____

Insurance Information

Primary Insurance: _____Social Security Number:_____
Subscriber Name:_____ Date of Birth:____/___/_____
Group Number: _____Identification Number:_____
Secondary Insurance: _____Social Security Number:_____
Subscriber Name: _____Date of Birth:____/____/_____
Group Number: _____Identification Number:_____

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS I hereby authorize direct payment to CI MA MD, Inc of any medical benefits payable to me for services provided at CI MA MD, Inc. I also understand that it is my responsibility to obtain my required referral authorization prior to my appointment time. I am also responsible for any co-payment, deductible, or patient portion on the day of service. I understand that if my account becomes delinquent, I will be held responsible for reasonable attorney's fees, court costs, and collection costs.

MEDICAL RECORDS RELEASE I hereby authorize CI MA MD Inc. to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by the payer.

* Signature _____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____
Signature

Notice to Consumers

Effective June 27, 2010, a new regulation mandated by Business and Professions Code Section 138, Title 16, California Code of Regulations Section 1355.4, requires physicians in California to inform their patients of the following:

"Medical doctors are licensed and regulated by the Medical Board of California" (800) 633-2322, www.mbc.ca.gov.

_____
Signature

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

-The patient refused to sign.

-Due to an emergency situation it was not possible to obtain an acknowledgement.

-We weren't able to communicate with the patient.

-Other (Please provide specific details).

_____ _____

Employee signature Date

Office Policies for Patients

The following information is provided to help you understand office policy and procedures. If you have any questions please do not hesitate to ask Dr. Ma or the office staff.

Broken Appointment Charges

When appointments are scheduled, 30 minutes is reserved for each follow up appointment. A $250 charge is incurred for appointments cancelled after hours the day prior, or the same day.

Telephone Consultation Charges

The charge for a telephone consultation reflects total time spent at $450 per hour. This includes the telephone call, writing the medical note, and sending a prescription to the pharmacy, if this is done.

Medication Refill Charges

Usually, medications run out because patients have not scheduled their follow-up appointment. Filling medication requires that Dr. Ma review the chart, interpret the situation, record a medical note justifying why the medication had to be refilled without an appointment, with instructions regarding the medication, dosage, quantity, and pharmacy number. The medication is then sent into the pharmacy. Medication Refill charges reflect total time spent at $250 per hour. We also provide a flat fee of $50 per prescription.

Policy for Phone/Email Communication

Phone and email communication is not intended for emergencies and may be unencrypted or otherwise not secure. NEVER send any confidential and/or health information, including medication refill requests. If you choose such communication, you will bear sole responsibility and release the practice including my doctor and Office staff from any liability for any adverse consequences.

If you are experiencing a **psychiatric emergency**, please either call the San Diego Crisis Line at 1- 888-724-7240 or go directly to the nearest hospital emergency room. I acknowledge that I have read and agree to the policy on phone/email correspondence.

High risk behavior. I will not attempt to end my life while I'm under the care of My Doctor and My Doctor's associates. If I have strong urges to end my life, I will call 911 or go to the nearest Emergency Room so I can be evaluated and treated before I do anything to harm myself. My family and I will not hold My Doctor and My Doctor's associates and My Doctor's office liable if I attempt to or succeed in ending my life.

Duty to Warn. My Doctor and Office staffs have the duty to inform the Department of Child or Adult Protective Services if I reveal to them that I or someone I know is actively abusing a minor or an elder. They also have the duty to inform the Police Department if I reveal to them that I am going to physically hurt or plan to kill someone.

Pregnancy. Psychiatric medications can be harmful to a fetus. If I want to become pregnant or if I discover that I am pregnant during my treatment, I will discuss my situation with my doctor and my doctor's associates **immediately**. I will not hold them liable if there are any adverse effects to my fetus due to my taking of psychiatric medications.

Treatment Outcome. The treatment of mental disorders, relationship problems, and other mental conditions require different treatments such as medications, psychotherapy, after-session assignments, support groups, and habit changes. There is ample evidence that these treatments work for some people at most of the time. However, there is no guarantee that any of these treatments will work for my specific condition. I'm willing to accept that fact going into treatment.

Long-term disability. I understand My doctor's office does not help the application of long-term disability.

Short-term disability. I understand My doctor and My doctor's associates have to evaluate me every week to assess if I am still qualify for it based on my condition. The maximum total duration won't exceed 6 months. My Doctor won't initiate the short-term disability under any circumstance if I am a new patient to the office.

Emotional support animal (ESA). I understand My doctor's office does not help to write any ESA letters or a letter to bring emotional animals aboard the flight.

Form/Letter fee. I agree to pay a fee for any forms/Letter I ask my doctor's office to complete. My doctor's office reserves the right to decide which form/Letter is appropriate based on the clinical evidence. The fee is ranged from $50.00 to $250.00 per case.

Urine Drug Screen (UDS). My doctor and My Doctor's associates can order UDS anytime during my treatment.

Public Encounter. At times, I may encounter My Doctor in a public setting. My Doctor wants to protect my privacy and will not acknowledge me as a patient unless I am comfortable revealing that information and acknowledge that I'm My Doctor's patient first. This also applies to My Doctor's associates and staff.

Termination. The doctor-patient relationship can be maintained between my doctor, my doctor's associates and me for as long as I continue to be compliant with recommended treatment. If I cancel my appointment and/or do not show up for my appointment, or violate any Office Policy, or I do not contact my doctor's office within the timeframe of their making three attempts to contact me or three months since the last appointment. My doctor's office can terminate this relationship and cease to provide any service including any refill request.

Legal Testimony

Legal matters may require the testimony of a mental health professional. Dr. Ma will decline to participate in any legal proceedings, even if it is on your behalf, as participation in any role outside of clinical care is a conflict of interest and will likely negatively interfere with the doctor/patient relationship.

Initial Evaluation

The initial psychiatric evaluation is a consultation focused on assessment, which is not guaranteed to establish doctor-patient relationship. This can be scheduled upto 30-60 minutes. If the evaluation cannot be completed within the allotted time, you have the option of extending the initial appointment time for an additional charge if Dr. Ma's schedule allows.

This agreement is between My Doctor and me,

_____

Print Patient's Name

Signature _____

Date _____

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.

What is this Notice and Why is it Important?

As of April of 2003, a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how I, CI MA, M.D., will protect your medical information, how I may use or disclose this information, and describes your rights. If you have any questions about this notice, please contact me at (858) 848-5386.

Understanding Your Health Information

During each appointment, I record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

• Basis for planning your care and treatment • Means of communication among the health professionals who contribute to your care • Legal document of the care you receive • Means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed • A tool with which I can assess and work to improve the care I provide

Your Health Information Rights You have the following rights related to your medical record:

• Obtain a copy of this notice. You can read this notice in the waiting room, and you can also obtain your own copy if you would like.

• Authorization to use your health information. Before I use or disclose your health information, other than as described below, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.

• Access to your health information. You may request a copy of your medical record from me at any time.

• Change your health information. If you believe the information in your record is inaccurate or incomplete, you may request that I correct or add information.

• Request confidential communications. You may request that when I communicate with you about your health information, I do so in a specific way (e.g. at a certain mail address or phone number). I will make every reasonable effort to agree to your request.

• Accounting of disclosures. You may request a list of disclosures of your health information that I have made for reasons other than treatment, payment or healthcare operations.

My Responsibilities

• I am required by law to protect the privacy of your health information, to provide this notice about my privacy practices, and to abide by the terms of this notice.

• I reserve the right to change my policies and procedures for protecting health information. When I make a significant change in how I use or disclose your health information, I will also change this notice.

• Except for the purposes related to your treatment, to collect

payment for my services, to perform necessary business functions, or when otherwise permitted or required by law, I will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.

When Can I Legally Disclose Your Health Information Without Your Specific Consent?

In order to facilitate your medical treatment.

For example: Your primary care physician or your psychotherapist might call me to discuss your treatment, and in that situation I would disclose information about your diagnosis, your medications, and so on.

In order to collect payment for health care services that I provide.

For example: In order to get paid for my services, I have my billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, I fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis.

In order to facilitate routine office operations.

For example: Occasionally, I dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.

Will I Disclose Your Health Information to Family and Friends?

While the new law allows such disclosures without your specific consent (as long as it contributes to your treatment), my office policy is that I will never share your clinical information with your family without authorization from you. The BIG EXCEPTION to this is if I believe you pose an immediate danger to yourself or

someone else—in that case, I will do whatever is necessary, even if that means breaching confidentiality.

Less Common Situations in Which I Might Disclose Your Health Information

• Workers compensation: I may disclose your health information to comply with laws relating to worker's compensation or other similar programs.

• Law enforcement: I may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order. This includes any information requested by the Department of Social Services (DSS) related to cases of neglect or abuse of children.

• Food and Drug Administration (FDA): I may disclose to the FDA your health information relating to adverse events due to medications.

• Business associates: I hire a billing company to send out bills to insurance companies. Some of the employees of this company have access to a small portion of your health information in order to allow them to do their job.

For More Information or to Report a Problem

If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact me, CI MA, MD at 858-848-5386. If you feel your privacy rights have been violated in any way, please let me know and I will take appropriate action.

You may also send a written complaint to: Department of Health & Human Services, Office of Civil Rights, Hubert H. Humphrey Building 200 Independence Avenue S.W. Room 509 HHH Building Washington, D.C. 20201

SUMMARY NOTICE OF HIPAA PRIVACY PRACTICES

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

This is a one-page summary of the longer notice that follows. Please read both the summary and the actual notice.

HIPAA allows me to share your health information without your specific consent in order to:

• Facilitate your treatment • Obtain payment by insurance companies • Transcribe records

I may disclose your health information to the following entities:

• Other health care providers and therapists • Insurance companies • Practice billing service • Practice transcriptionist

• Workers Compensation Boards • The FDA • Law enforcement and DSS

Note: I will NOT share your information with your family without your specific consent, unless somebody's health is in immediate danger.

Authorization to Release and/or Obtain Health Information
Patient Full Name:_____

Date of Birth:_____

*Check all that apply

___ I hereby authorize Dr. MA to release my medical information **to** _____.

___ I hereby authorize Dr. MA to obtain medical information **from**_____.

Address of Individual or
Facility:_____
Telephone of Individual or Facility:_____
Fax:_____

Information to be Released/Obtained may include:

History and Physical Progress Notes Consultations Discharge Summary Operative Reports EKG Report Laboratory Reports Radiology Reports Outpatient Clinic Records Emergency Medicine Report Other Diagnostic Reports Immunizations/Vaccinations

Specific Authorizations: Check all that apply:

___ I authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.

___ I authorize the release of information pertaining to mental health diagnosis or treatment.

___ I authorize the release of HIV/AIDS testing information

Purpose of Release/Obtaining Medical Information: Check all that apply:

___ Coordination of Care ___ Continuity of Care

___ Billing and payment ___ At request of client or client representative

___ Other:

Effective Date of Authorization:_____

Duration of Authorization:_____

Please Note: Dr. CI MA, like many other health organizations, physicians, hospitals, and health plans, is required by state and

federal law to keep your health information confidential. For full details of Dr. CI MA's privacy policies, please refer to the Notice of Privacy Practices. If you do authorize disclosure of your protected health information to an individual or organization who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

My Rights

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a clam, or 4) to create health information to provide to a third party. Under no circumstances am I required to authorize the release of mental health records.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. CI MA and/or the healthcare professional or facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- I am entitled to receive a copy of this Authorization.

Signature _____
Date:_____

Signature of Client or Client's Legal Representative

Telepsychiatry Consent Form

Telepsychiatry provides psychiatric services using interactive video conferencing tools in which the psychiatrist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care without the need to visit the office and travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternative to telepsychiatry include traditional face to face sessions.

Your Rights:

1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry;
2) I understand that the interactive video conferencing tool, Doximity vs PsychologyTodayLink is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.
3) I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time.
4) I understand that Dr. MA has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time;
5) I understand that all rules and regulations which apply to the practice of medicine in the State of California also apply to telepsychiatry.

Your Responsibilities:

1) I will not record any telepsychiatry sessions without the prior written consent of Dr. MA and I understand that Dr. MA will not record telepsychiatry sessions without my consent;
2) I will inform Dr. MA if any other person can hear or see any part of our session before the session begins. Likewise, Dr. MA will inform me if any other person can hear or see any part of the session before the session begins.
3) I understand that I MUST be a resident of California to be eligible for telepsychiatry services from Dr. MA.
4) I understand that my Initial Consultation will not be done by telepsychiatry except in special circumstances under which I will be required to verify my identity to Dr. MA's satisfaction before the evaluation.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize Dr. MA to use telepsychiatry in the course of diagnosis and treatment.

X_____
Patient or Parent/Legal Guardian Signature.

X_____
Patient's name.

X_____
Date