***We are not accepting any New Patients who are currently taking any controlled pain medications**
***Note: completion of the following paperwork and Initial Screening Exam does not guarantee acceptance as a New Patient in our practice**

Patient Name: _____ Patient #:_____ Date: _____ 1

Richard Heidenfelder M.D.
Child/Adolescent and Adult Psychiatry
PATIENT INFORMATION FORM

PATIENT NAME_____
First middle initial last
BIRTHDATE_____

PATIENT SEX: _____Male _____ Female PATIENT SSN_____

HOME ADDRESS_____CITY/STATE_____
ZIP CODE_____

HOME PHONE # (__)_____
E-MAIL_____

ALTERNATE PHONE # WHERE WE MAY REACH YOU
(__)_____

RESPONSIBLE PARTY NAME _____
REL TO PT _____

PHONE # (__)_____
ADDRESS _____

CITY/STATE_____ ZIP CODE_____

EMPLOYER _____
PHONE # ( ) _____

PRIMARY INS. _____

INSURED NAME _____
PHONE #_____

REL TO PT_____ BIRTHDATE_____

SOCIAL SECURITY NO._____ GROUP/PLAN_____

EMPLOYER NAME, ADDRESS, PHONE #
_____

SECONDARY INS. _____

INSURED NAME _____

PHONE # _____

A COPY OF YOUR DRIVERS LICENSE and INSURANCE CARD IS NEEDED
PAYMENT OF SERVICES IS HANDLED PRIOR TO YOUR SESSION

All reasonable requests for confidential handling of your health information by alternative means will be granted:

❖ May we leave a message on your home answering machine? Y___ N ____

❖ Do you have an alternate phone number we may use? Y___ N ____ Phone # _____

❖

Emergency Contact Name _____ relationship_____
& Phone Number _____

- ❖ May we share information regarding appointments or billing inquiries only with your spouse or an immediate family member? Y___ N___ Names: _____

- ❖ Do we have permission to contact you by email? Y____ N____

- ❖ If the patient is a Minor, are biological parents: married ___ never married___ divorced ___. Minor Child Treatment Information may be shared with Non-Custodial Parent (if not specified otherwise in the court order) Y__ N __

- Non-Custodial Parent Name: _____

  Please complete the following section only if you want communications regarding your health care information or billing sent to an alternate address other than your residence.

  _____
  (Street Address)

  _____ _____ _____
  (City) (State) (Zip Code)

Richard Heidenfelder M.D.-Effective 4/22/13

We are committed to providing our patients with the best possible care and we are pleased to discuss our professional services with you at any time. Your clear understanding of our Office Procedures and Financial Policies is very important. All patients must complete our "Patient Information Form" before seeing the Dr. Heidenfelder
Payment of services is handled prior to your session. If you cannot pay, you may be asked to reschedule. We accept cash, checks, Visa, MasterCard, Discover, American Express, and Debit. If a check is returned for insufficient funds, we will not accept another check from the patient. Payment will have to be cash, credit or debit. There is a $25 returned check fee. We do not accept temporary or post-dated checks if you are a new patient.

NOTE: You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you feel you were charged in error, please discuss this matter with our office manager.

Childcare is not provided for children. Please do not leave children unattended in the reception area.

In the event of a Divorce, we must have a copy of the Divorce Decree signed by a judge. The decree must state which parent has Managing Conservatory privileges for the minor child.
At initial appointment, biological parent must be in attendance.

Annual Membership Fee

Our Practice is a membership-based medical practice based on treating our members/patients the way we would want our family to to be treated.
Our members support the practice by paying an annual membership fee of $300, which helps us provide the services and benefits beyond what insurance covers.

*A detailed description of the services provided through membership can be found on our website. RichardHeidenfelderMD.com

*By signing below you are agreeing to the terms of the Membership Agreement as outlined.

Should you have any problems regarding your account or about the filing of claims, fees, or billing records, please do not hesitate to ask our Business Office Staff.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES OF RICHARD HEIDENFELDER M.D.

_____ _____ Signature

_____Date

RICHARD HEIDENFELDER M.D.

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT:

___ ITEM 1 – **LETTERS AND/OR FORMS**
Initial/ The Annual Membership Fee covers the expense for most forms and/or letters that must be completed in this office by any practitioner or office staff.

___ ITEM 2 – **THERAPY SESSIONS**
Initial/ Therapy sessions are scheduled for 30 or 45 minutes. To ensure that you receive your entire session, please be prompt for you appointment.

___ ITEM 3 – **CONFIDENTIALITY**
Initial/ All information is guarded by strict confidentiality. We require your written consent in order to release / obtain information. Any additional person that is willfully allowed to be present during an appointment is considered implied consent to release information.

___ ITEM 4 – **CONSENT FOR TREATMENT – CONSENT MUST BE SIGNED PRIOR TO THE START OF YOUR Initial APPOINTMENT**
I hereby give consent for myself or the above named patient to be treated/tested by RICHARD HEIDENFELDER M.D. If the above named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court documents, that I have the legal right to request treatment for the above named minor. If you are 15-17 years of age, you must co-sign. If you are 18 years of age, you must sign yourself and are allowed the right to choose whether you wish anyone/parents to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co-joint therapy. Patients under 18 years of age will only be seen with a parent or guardian present.

__ ITEM 5 – **TERMINATION OF TREATMENT**
Initial/ Physical Assault, verbally threatening behavior towards staff, other patients, or physical property, and/or significant disruption of the office environment will be cause for immediate termination of treatment and you will be held responsible for damages. Firearms and other weapons are prohibited, with exception for an officer of the law.
Non-compliance with treatment (missed appointments, failure to follow treatment plans, misuse of medications) is grounds for termination of treatment.

___ ITEM 6 – **CANCELLATIONS**

In general we do not charge for missed or late cancelled appointments. However, chronic missed or late cancelled appointments could lead to termination of treatment from our practice.
Please be courteous and provide as much notice as possible when you need to cancel/reschedule your appointment.

___ ITEM 7 – **EMERGENCY SERVICES**

Initial/ I agree to contact 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

___ ITEM 8 – **FINANCIAL POLICY**

Initial/ I acknowledge that I have read and understand the financial policies of this office.

___ ITEM 9 – **NOTICE OF PRIVACY PRACTICES**

Initial/ I acknowledge that I have received a copy of the Notice of Privacy Practices of this office effective April 21, 2013.

___ ITEM 10– **BILLING INQUIRY**

Initial/ If you have billing questions, we will be pleased to help you. Contact our billing office at drh.office447@gmail.com.

____ITEM 11-**MEDICATION REFILLS**

Initial/ Medication refills are written at each appointment. Patients should not require any refills prior to their next appointment unless an appointment is missed or cancelled. There is a $25 charge for refills due to missed/cancelled appointments. Please check with your pharmacy first before calling/emailing the office requesting a refill as often times you may have refills available. Refills will not be given in cases of pharmacy errors. Patients will need to speak to their pharmacy directly in those cases.

____**ITEM 12-APPOINTMENT CANCELLATION/RESCHEDULING**

Occasionally we may need to cancel or reschedule your appointment with less than 24 hours notice. If possible we will call you directly to notify you of such changes.
However, our primary means of communication are via text messaging and email.
ALL patients are STRONGLY encouraged to maintain accurate contact information with our office and STRONGLY encouraged to check their email and text messages prior to each and every appointment before departing for their appointment.

Items 1-12,(initialed by me, indicate my understanding of legal Terms and Conditions in connection with the treatment of patient.

Patient Signature_____

Patient Initials_____

Date_____

Richard Heidenfelder M.D.
Child/Adolescent and Adult Psychiatry
447 9th Ave.
San Diego, CA 92101

Clients' Rights

1. **You have all the rights of any other resident of the State of California and the United States of America.**
2. You have the right to not be discriminated based on age, race, ethnicity, gender, sexual orientation, religion, national origin, physical or mental disability, or other attributes.
3. **You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.**
4. You have the right to be free from abuse, neglect, and exploitation.
5. **You have the right to be treated with dignity and respect**.
6. You have the right to be told about the treatment you will be given, the risks, side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.
7. **You have the right to accept or refuse treatment after receiving this explanation.**
8. You have a right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
9. **You have the right to know the qualifications of the staff responsible for your treatment.**
10. You have the right to refuse to take part in research without affecting your regular care.
11. **You have the right not to be given medication you don't need, or too much medication.**
12. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
13. **Unless otherwise provided by law, you have the right to withdraw at any time you permission for something you agreed to earlier.**
14. You have the right to make a complaint and receive a fair response from this facility within a reasonable amount of time.
15. **You have the right to contact and consult with counsel at your expense.**
16. You have the right to select practitioners of your choice at your expense.
17. **You have the right to choose whether your parents may be present and participate in your treatment if you are at least 18 years of age.**

I acknowledge having read and understood the above client rights.

_____ _____

Signature of Patient Date

_____ _____
Signature of Parent or Legal Representative Date

_____ _____
Signature of Witness Date
4

If you have any questions about this notice, please contact HIPAA grievance office. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

WHO WILL FOLLOW THIS NOTICE:
Any physician or health care professional authorized to enter information into your chart, and other office personnel. In addition we may share with each other and third party specialists for treatment, payment, and purposes described in this notice.

WE ARE REQUIRED BY LAW TO:
Make sure that medical information that identifies you is kept private. Give you notice of our legal duties. Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU
Treatment- We may use medical information about you to provide you with medical treatment services. We may disclose medical information about you to people outside the office who may be involved in your care. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

Payment- We may use and disclose medical information about you so that treatment and services you receive at our office may be billed to and payment collected from you, and insurance company or a third party.

Appointment Reminders- We may use and disclose medical information to contact you as a reminder that you have an appointment for medical services at the office. We do notify our patients by telephone.

As Required By Law- We will disclose medical information about you when required to do so by federal, state, or local law.

SPECIAL SITUATIONS
Health Oversight Activities- We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes- If you are involved in a lawsuit or a dispute we may disclose medical information about you in response to a court order. We may also disclose information about you in response to a subpoena.

Coroners, Medical Examiners, and Funeral Directors- We may release medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU
Right to Inspect and Copy- If you request a copy of the information we may deny your request due to mental health liabilities.

Right to Amend- If you feel that medical information we have about you is incorrect or incomplete you may as us to amend the information. In addition you must provide a reason that supports your request. We may deny your request for an amendment but your request will be put into your permanent file as you requested it be changed.

Right to Request Restrictions- You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment, or health care operations.

Right to paper copy of this notice- You have the right to a paper copy of this notice. To obtain a paper copy of this notice please contact us.

CHANGES TO THIS NOTICE
We reserve the right to change this notice.

COMPLAINTS
If you believe your privacy rights have been compromised, you can file a complaint with our Grievance Officer at 619-435-4088.

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this notice will only be made with your written permission. You may revoke that permission in writing at any time; if you do we will no longer use or disclose medical information. Understand that we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Patient & Family History – New Patients

Presenting Problem:
Please state the reason and/or symptoms that brought you here today:
_____
_____
_____
_____
Are there any significant events associated with the above reason? Yes____ No ____
If yes, please provide more information:
_____
_____

Check all symptoms you have been experiencing:

( ) recent weight gain How much? _____
( ) recent weight loss How much? _____
( ) difficulty falling asleep (insomnia) ( ) Excessive sleeping ( ) Fatigue
( ) Middle of the night awakening ( ) Decreased energy ( ) Lack of motivation

( ) Restlessness or agitation ( ) Decreased appetite ( ) Increased appetite
( ) Frequent mood swings ( ) Frequent anger ( ) Irritability

( ) Complaints of despair, hopelessness, worthlessness ( ) Inattention
( ) Inability to experience pleasure ( ) Inability to express feelings
( ) Withdrawal from others ( ) Difficulty concentrating
( ) Loss of Libido ( ) Loss of though process
( ) Difficult focusing resulting in unfinished task

Are you presently having **thoughts of suicide?** Yes____ No____
If yes, please provide more information:
_____
_____
_____
Have you ever made a **suicide attempt?** Yes____ No____
If yes, please provide more information. (When, how)
_____
_____
_____

Patient Medical History:

Have you ever had **psychiatric treatment?** Yes____ No____
If yes, please describe: Date: _____
Provider:_____
Reason:_____
_____

History of Substance Use and/or Abuse:

Have you ever used **drugs?**( )no ( )yes

Substance	Age began	Frequency/amount	Last time used
1.			
2.			
3.			

Have you ever been in **treatment** (hospital or outpatient) **for drug** and or **alcohol abuse?** Yes____ No____ If yes, please describe, providing date, provider and type of treatment:

_____
_____

Do you use any **tobacco product**? Yes____ No____

Allergies to medications?

History of any of the following conditions? Yes____ (Check below), None _____

- ☐ Meningitis
- ☐ Hepatitis
- ☐ Mononucleosis
- ☐ Renal KIDNEY problems
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood pressure
- ☐ Low Blood pressure
- ☐ Rheumatic fever
- ☐ Seizures (other than febrile)
- ☐ Serious head injury. With or without loss of consciousness? (circle)
- ☐ Other: _____

Surgery: Yes____(Check below), None ____

- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Gallbladder removal (Cholecystectomy)
- ☐ Hysterectomy (partial or complete?)
- ☐ Other:

(specify)_____

_____

Current Medical Conditions (diabetes, seasonal allergies, high blood pressure, etc.):

_____

_____

Females: Last menstrual period:_____

Are you currently pregnant? Yes_____ No _____

Breastfeeding? Yes_____ No_____

Developmental history **(Children and adolescents ONLY):**

- ▪ Was the pregnancy _____ planned or _____ unplanned?
- ▪ Was it full-term? ____Yes ____ No
- ▪ Normal pregnancy? Yes _____ No(explain) _____
- ▪ How did the mother feel about this pregnancy? _____
- ▪ How did the father feel? _____
- ▪ Any alcohols, drugs, or medications used during pregnancy? ____ Yes __NO
- ▪ If yes, please describe:
- ▪ Were there any problems with the pregnancy?_____
- ▪ Delivery: Normal vaginal ____ C-Section _____
- ▪ Was the baby _____ breast fed _____ bottle fed _____ both?
- ▪ Who was the primary caretaker for the child? _____

- Estimate when your child first:

  Smiled _____ Crawled _____ Walked _____
  Said first word _____
  Sat up on own _____
  Stood Ran _____
  Said phrases _____
  Fed self _____ Dressed self _____ Toilet trained _____

Current Medications: (Example: Prozac 20mg one a day. Include **all** meds, not just psychiatric ones. Also include any over-the-counter meds, vitamins, etc.)

Medication Name	Dose	How Often	Reason/Treatment of

Family Medical History: check & list – i.e. Mother (M), Father (F), Paternal Grandmother (PGM), etc.)

- ☐ Diabetes_____
- ☐ Thyroid disorder_____
- ☐ Heart attack or heart disease_____
- ☐ High blood pressure_____
- ☐ Stroke_____
- ☐ Alzheimer's Disease_____
- ☐ Parkinson'Disease_____
- ☐ Migraine Headaches_____
- ☐ Other (list):_____
-

Family Psychiatric History: (check & list as above)

- ☐ Depression_____
- ☐ Bipolar Disorder (Manic Depression)_____

Schizophrenia_____

- ☐ Alcoholism_____

Family Psychiatric History Con't: (check & list as above)

- ☐ Drug abuse or dependency_____
- ☐ ADHD or ADD_____
- ☐ Obsessive Compulsive Disorder_____
- ☐ Anxiety or Panic symptoms_____
- ☐ **Other** (list)_____

Religious preference: _____
Are there any cultural issues or religious beliefs that might affect your treatment?
No____Yes (explain)
_____
_____

Current Marital Status: Married____, Divorced____, Separated_____, Single____, Widowed____, Number of Marriages____, **Non-applicable (child)__**
Years in current marriage? _____
Is spouse supportive? Yes____ No (explain)_____

Children? Yes____ How many? _____

Child's Name	Age	Biological, step, adopted, foster
1.		
2.		
3.		

Describe who lives in household: (e.g. husband, wife, children, mother, father, siblings, pets,
etc.)_____
_____
_____

Education: (Check all that apply.)
☐ Currently in _____ grade at _____ (name of school) in _____(school district).

- ☐ Dropped out of school in the _____grade.
- ☐ High School graduate Major/Skill learned?_____
- ☐ GED Major/Skill learned?_____
- ☐ Some college Major/Skill learned?_____
- ☐ 2 year degree (college)
- ☐ 4 year degree (college)
- ☐ Graduate degree
- ☐ Other _____

Work History of Patient: (Current job, how long at job, do you enjoy your work, work stressors?)
_____
_____
_____

Family of origin: Grew up in intact family (i.e. Mother & father stayed married.)

- ☐ Parents divorced when patient _____years old. Patient lived with: mother____ father____.
- ☐ History of physical abuse at hands of _____.
- ☐ History of sexual abuse at hands of _____.
- ☐ History of emotional abuse at hands of _____.
- ☐ Siblings: brothers_____ sisters_____ (how many?)
- ☐ Close family relationships.
- ☐ Not very close family relationships.

Completed by: _____ **(Patient or Parent/Guardian)**
(Signature)

Patient Guidelines and Consent for Use of E-mail Communications Richard Heidenfelder M.D.

To better serve our patients, this office has established a website for some forms of communication. Our website will allow you to send messages to the appropriate staff member in regards to scheduling, practitioner questions, billing issues, and medication refills. Please remember, however, that this form of communication is **not appropriate for use in an emergency.** The turnaround time for routine patient communications is within twenty-four hours. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.**

Types of communication that are appropriate for e-mail include:

scheduling inquiries
non-urgent medical advice
billing or insurance questions
test and lab results
home health monitoring reports
prescription refill requests (per practice policy) educational materials

When sending e-mail, please put the subject of your message in the subject line so we can process it more efficiently. Some forms of communication (e.g., HIV, mental health, work-related injuries and disability) are not appropriate for e-mail. Also, be sure to put your name, date of birth, and return telephone number in the body of the message. We also ask that you acknowledge receipt of e-mails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above e-mail policy.

_____
Patient Signature

_____
Date

_____
Witness (optional)

_____
Email Address