NOTE-PRIVATE/SELF PAY PATIENTS: We are a Membership/Concierge based practice-(explained under Office Policies tab). For Private and Self Pay patients we charge a yearly fee-not covered by insurance- that all Private/Self Pay patients are required to pay in full by their third appointment. If you request a New Patient appointment you acknowledge that you have read and understand and agree to the Membership Free Agreement.

***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

RICHARD HEIDENFELDER, M.D.
826 ORANGE AVENUE
SUITE 605
CORONADO, CALIFORNIA 92118

OFFICE AND FINANCIAL POLICIES AGREEMENT

INTRODUCTION:

Welcome to our medical office. We are committed to providing our patients with the best possible care. Your clear understanding of our office and financial policies is very important, thus, we are available to discuss our professional services with you at any time. In addition to our office and financial disclosures, we value an open forum for a long-term physician-patient relationship. This Agreement is intended to communicate our practice values, adherence to strict consumer laws and all state and federal healthcare laws.

All patients must complete our "Patient Information Form" before seeing Dr. Heidenfelder. Please take time to read carefully the following paragraphs and communicate your consent to our legal and treatment requirements, and goals by signing at the end. Thereafter, you will be given your copy. If you have any questions during this process, please, do not hesitate to ask.

With all the new changes in healthcare, reimbursement to physicians has decreased making it even more difficult to maintain a solo practice. For years, at patients' requests Dr. Heidenfelder has provided letters, disability forms, and other medically related documents and services for free. He is determined to maintain his accessibility for his patients, even if it that means he works for no compensation after hours and on weekends. In order to remain in business and provide a personal touch of a true medical doctor sharing in the healing of his patients, Dr. Heidenfelder has taken example from many other dedicated medical practices and will have to charge a yearly **Membership Fee**

Dr. Heidenfelder and our office staff take pride in going above and beyond most medical offices in order to provide our patients with the treatment and service they deserve.

AGREEMENT

This is an Agreement entered into on ______________________, 20 _____, by and between **Dr. RICHARD HEIDENFELDER, whose practice is located at 447 9th Ave, San Diego CA 92101, and**
____, (**Patient**).

NOW, THEREFORE, the parties agree as follows:

BACKGROUND

In exchange for certain fees paid by Patient for **Annual Membership Fee** Dr. Richard Heidenfelder agrees to provide Patient with the Services described in this Agreement on the terms and conditions set forth in this Agreement.

DEFINITIONS:

Applicable Law. Federal Law and Regulation: Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI. Regulation, Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).

Non-Covered Services. A non-covered service is a service, item, or supply for which insurance reimbursement is not available.

Patient. A patient is for whom the Physician shall provide Services and provide their signature to this agreement.

Services. Services includes a package of non-Medical treatments (collectively referred to as “Services), which are offered by the Practice. Services will be listed in this Agreement.

Terms. This Agreement starts on date signed by the parties below and shall continue for a period of one month, automatically renewed, unless the Patient notifies the Practice in writing **thirty (30) days** prior to the end of the term that the Patient wants to terminate the contract.

Fees. In exchange for the services in the Agreement, the Patient agrees to pay the Practice at the time this Agreement is started, the amount as set forth in this **Agreement**. The fee is in payment for the services provided to Patient during the term of this Agreement. If this Agreement is cancelled by either party before the Agreement termination date, then the Practice shall refund the Patient’s prorated share of the original payment, remaining after deducting individual charges for services rendered to Patient up to cancellation.

Annual Membership Fee

Fee schedule shall be as follows:

One Year Individual: Three hundred dollars ($300.00) per year. Payment due at signing of this Agreement.

PAYMENT:

Payment for non-emergency services is required prior to your session. If you are unable to render payment, the front office will reschedule your appointment. Our office accepts cash, check, Visa, MasterCard, and Discover. If a check is returned for insufficient funds, future payments cannot be made with checks. There is a **$25 returned check fee**. For new patients, we do not accept temporary/post-dated checks.

OUTSTANDING BALANCES:

Any patients that have a balance due may be refused any non-urgent treatment until all outstanding balances are paid in full. 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.

24 HOUR NOTICE OF CANCELLATION:

Unless notified twenty-four (24) hours in advance, there will be a fifty dollar ($50) charge for missed/canceled appointments. Please do not rely on appointment reminder calls, as this is a courtesy. Having three (3) or more "no shows" or cancellation of appointments can result in termination of treatment. Please help us serve you better by keeping scheduled appointments.

INSURANCE:

Patient understands and agrees that neither Practice nor its physicians make any representations whatsoever that any fees paid under this Agreement are covered by Patient's health insurance or other third-party payment plans applicable to the Patient. However, if the services rendered are covered by insurance, Practice will seek reimbursement from applicable insurance plan, whether private insurance and/or government sponsored insurance. In the event that the services are not covered, Practice will seek reimbursement from Patient. The patient shall retain full and complete responsibility for any such determination.

NO INSURANCE OR OTHER MEDICAL COVERAGE:

Patient acknowledges and understands that this Agreement is **not** an insurance plan, and **not** a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services, or any services not personally provided by Practice, or its physician.

Patient acknowledges that Practice and its physician have advised patient to keep in full force such health insurance policy(ies) or plans that will cover Patient for general healthcare costs.

Patient acknowledges that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any

existing or future health insurance or health plan coverage that Patient may carry.

TERM;TERMINATION:

This Agreement will commence on the date first written above and will extend monthly thereafter. Both Patient and the Practice shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving **30 days prior written notice** to the other party. Unless previously terminated as set forth above, at the expiration of the initial one-month term (and each succeeding monthly term), the Agreement will **automatically renew** for successive monthly terms upon the payment of the monthly fee at the end of the contract month.

COMMUNICATIONS:

Patient acknowledge that communications with the Physician using e-mail, facsimile, video chat—telehealth, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. As such, Patient expressly waives the Physician's obligations to guarantee confidentiality with respect to correspondence using such means of communication. Patient acknowledges that all such communications may become part of Patient's medical records.

EMAIL COMMUNICATIONS:

By providing Patient's e-mail address Patient authorizes the Practice and its Physicians to communicate with Patient by e-mail regarding Patient's "protected health information" (PHI)(as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations).

By inserting Patient's e-mail address below, Patient acknowledges that:

- [x] E-mail is not necessarily a secure medium for sending or receiving PHI and there is always a possibility that a third-party may gain access and confidentiality may be compromised, despite diligent and good faith measures taken by the Practice and its Physician in securing the Patient's PHI;

- [x] E-mail communications are considered a part of the Patient's permanent medical record; and

- [x] Patient understands and agrees that e-mail communication is not the correct

means of communication for emergency or other time-sensitive issues. Nor is e-mail communication the appropriate means for questions about sensitive information.

- [X] If Patient does not receive a response to an e-mail message within 24 hours, Patient agrees to use another means of communication to contact the Physician.

- [X] Neither the Practice nor the Physician will be liable to Patient for any loss, cost, injury, or expense caused by, or resulting from a delay in responding to Patient as a result of technical failures including, but, not limited to: Technical failures attributable to any internet service provider, power outages, failure of any electronic messaging software, failure to properly address e-mail messages, failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, any interception of e-mail communications by a third party; or patient's failure to comply with the guidelines regarding the use of e-mail communications outlined in this Agreement.

- [X] **IN THE EVENT OF AN EMERGENCY, OR A SITUATION IN WHICH THE PATIENT COULD REASONABLY EXPECT TO DEVELOP INTO AN EMERGENCY, PATIENT SHALL CALL 911 OR THE NEAREST EMERGENCY DEPARTMENT AND FOLLOW THE DIRECTIONS OF THE EMERGENCY PERSONNEL**.

CHANGE OF LAW:

Patient understands that healthcare and consumer protection laws change, and in complying with those laws the Practice wants to protect its Patients. Thus, if any change in federal, state or local law, regulation or rule affects the Practice/Physician and/or Patient's rights, obligations or operations associated with any term or condition of this Agreement, or if either party to this Agreement reasonably believes in good faith that such change will adversely affect that party's rights, obligations or operations associated with this Agreement then that party may, upon written notice, require the other party to renegotiate the terms of this Agreement. If the parties are unable to reach an agreement within forty-five (45) days after the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party. We reserve the right to amend the Office Policies/Non-Covered Services Contract at any time.

SEVERABILITY:

If for any reason, any provision of this Agreement is determined by a court of competent jurisdiction to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected. The provision deemed legally invalid

shall be deemed modified to the minimum extent necessary to make that provision consistent with the applicable law. In its modified form, that provision shall then be enforceable.

REIMBURSEMENT FOR SERVICES RENDERED:

If this Agreement is held to be invalid for any reason, and, therefore, if the Practice needs to refund all or any portion of the monthly fees paid by Patient, then Patient agrees to pay the Practice the reasonable value of the Services actually rendered to Patient.

AMENDMENT:

If applicable law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference and deemed part of this Agreement as though they had been expressly set forth into this Agreement and shall be deemed a part of this Agreement as thought they had been expressly set forth in this Agreement. Otherwise, no amendment to this Agreement shall be binding on a party unless it is made in writing and signed by all the parties.

ASSIGNMENT:

This Agreement is personal to the Patient, thus, this Agreement may not be assigned or transferred by Patient.

LEGAL SIGNIFICANCE:

Patient acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Patient also acknowledges having had a reasonable time to read and ask questions regarding this Agreement and to consider all alternatives and implications to signing this Agreement and does so without general or medical duress, and/or incapacitation. Thus, Patient is satisfied with the terms and conditions of the Agreement.

ENTIRE AGREEMENT:

This Agreement contains the entire agreement between the parties and supersedes any oral or written understandings and agreements regarding the subject matter of this Agreement.

JURISDICTION/GOVERNING LAW:

This Agreement shall be governed and construed under the laws of the

State of California and all disputes arising out of this Agreement shall be settled in a court of proper venue and jurisdiction in the County of San Diego, without giving effect to conflict of laws.

<u>SERVICE</u>:

All written notices are deemed served if sent to the address of the party written above, by first class U.S. mail, certified with return receipt or by personal service with signed affidavit.

<u>MISCELLANEOUS</u>:

This Agreement shall be construed without regard to any presumptions or rules of construction against the drafting party. Captions in this Agreement are used for convenience only and shall not limit, broaden or quality the text.

____

Dr. Richard Heidenfelder
619-435-4088 (office)
619-435-4088 (fax) Email:

____

Patient (printed)

____

Patient Signature

____

Patient E-mail Address
Pages to follow:

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT:

___ ITEM 1 – 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 fifteen to seventeen (15-17) years of age, you must co-sign.

If you are eighteen (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 eighteen (18) years of age will only be seen with a parent or guardian present.

___ ITEM 2 – THERAPY SESSIONS

Initial/ Therapy sessions are scheduled for thirty or forty-five (30 or 45) minutes. So that you receive your entire session, please be prompt for your 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 implies consent to the release of information.

___ ITEM 4 – LETTERS AND/OR FORMS

Initial/ The *Practice Administration Fee* covers the expense for any forms and/or letters that must be completed in this office by any practitioner or office staff.

___ 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, and violation of any office policies) is grounds for termination of treatment.

___ITEM 6- OFFICE BEHAVIOR

Initial/ All patients are expected to act professionally and appropriately at the office.

No eating or drinking in the office. Food and beverages may be consumed outside on the front porch.

No cursing, inappropriate language, or inappropriate discussions are allowed. Any patient(s) who are deemed to be behaving inappropriately will be asked by the office staff to reschedule their appointment.

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

We ask that ONLY essential family members or mental health providers attend scheduled appointments. Our office is small and seating is limited and is provided for patients and essential family members only. Any additional visitors may be asked to leave the office property, (including the front porch area), and wait off premises.

Please do not disrupt office staff. Any questions/comments/requests beyond the required information needed at your appointment will need to be submitted to the office via email.

Please do not use your cell phone in the office/waiting area.

Do not discuss confidential patient information, appointment time, etc., with other patients who are waiting.

Patients violating any of the above rules may be asked to reschedule their appointment.

Any patients who repeatedly violate these rules will be terminated from the practice.

___ ITEM 7 – CANCELLATIONS

Initial/ New Patient Evaluation Cancellations must be made 5 days before your session. Your session time is reserved for you and you will be charged the full $100 deposit required to hold the Initial Evaluation appointment time. There is a $50.00 no-show fee for late cancellations or

missed appointments. Our office policy allows three no-show fees before terminating services.

You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you are late for your appointment and are asked to reschedule you will charged a $50 no-show fee. If you feel you were charged in error, please discuss this matter with our office manager.

___ ITEM 8 – EMERGENCY SERVICES

Initial/ I agree to contact the office at 619-435-4088 and call 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

___ ITEM 9 – FINANCIAL POLICY

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

___ ITEM 10 – 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 11– BILLING INQUIRIES

Initial/ If you have billing questions, we will be pleased to help you. Contact our billing office at 619-435-4088.

___ITEM 12 – REFILLS

Initial-Refills will not be given in cases of pharmacy errors. Patients will need to speak to their pharmacy directly in those cases.

By initializing Items 1 – 12, I indicate my agreement and understanding of my responsibility and expectations in receiving proper treatment in a timely manner by Richard Heidenfelder, M.D.

____

Dr. Richard Heidenfelder
619-435-4088 (office)
619-435-4088 (fax) Email:

____

Patient (printed)

____

Patient Signature

____

Patient E-mail Address

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT PRIVACY NOTICE.

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.

This privacy notice is effective as of ________________________ *[date]*

PRIVACY LAW.

At the practice of Richard Heidenfelder MD we are committed to protecting the privacy rights of our patients. You have a variety of rights under the federal law known as HIPAA, the Health Insurance Portability and Accountability Act of 1996, and the related Privacy Rule published by the U.S. Department of Health and Human Services. Those rights are described in this notice.

Under the HIPAA and the Privacy Rule, we have certain obligations:

- We are required by law to maintain the privacy of protected health information.
- We must provide you with this notice of our legal duties and privacy practices with respect to your protected health information.
- We are required to abide by the terms of the privacy notice currently in effect.

We reserve the right, when we change a privacy practice, to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If we do update our policy, we will provide you with a new notice by posting a notice on our website, and sending you an email or paper copy of the latest policy.

WHAT IS PROTECTED HEALTH INFORMATION?

Health information includes more than just information about medical procedures. The term includes all information that relates to:

- The past, present, or future physical or mental health or condition of an individual.
- The provision of health care to an individual.
- The past, present, or future payment for the provision of health care to an individual.

Health information that identifies an individual or which can probably be used to identify the individual is protected by law. This protected health information is known as PHI. When treating you, we need to use all available relevant medical information. However, in other circumstances, we will use the minimum PHI necessary for the transaction.

WHEN WE CAN USE HEALTH INFORMATION WITHOUT WRITTEN AUTHORIZATION OR REACTION FROM YOU.

In the following circumstances, we are permitted to use or disclosure health information without obtaining written consent (called "authorization"), or without giving you a chance to object or agree to the use of disclosure. Remember, we are talking only about privacy of information; obviously you are given a chance to object to or consent to medical procedures.

FOR TREATMENT. Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. For instance, if we refer you to a specialist, we will provide your relevant files to that specialist.

FOR PAYMENT. Payment means both the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care; and by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan]. For instance, we will share necessary information with your insurance company to help obtain payment for your doctor visits.

FOR HEALTH CARE OPERATIONS. Health care operations include (1) conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines; (2) reviewing the competence or qualifications of health care professionals and plans evaluating practitioner and provider performance; or (3) certain underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. For instance, we may occasionally share your information with the managing doctor in this clinic when we are reviewing the work of our staff.

USES REQUIRING YOUR CONSENT.

We may make certain other uses and disclosures of your health information that require your consent. We will only make these uses or disclosures with your written authorization. You may revoke this

authorization in writing at any time. However, the revocation does not affect actions taken before we receive it.

ADDITIONAL PRIVACY RIGHTS YOU CAN EXERCISE.

You have a variety of rights under HIPAA and the Privacy Rule that you may choose to exercise. These consist of:

- The right to request restrictions on certain uses and disclosures of protected health information. You can ask us to restrict use or disclosure of PHI for health care operations, restrict disclosure to persons involved in the individual's health care, or payment for health care. You can ask us to limit disclosures made to notify family member or others about the person's condition or location. We are not obligated to agree to these restrictions. If we do agree, we must honor that agreement (except in certain emergency situations).
- The right to receive confidential communications of protected health information. For instance, you may wish to be contacted only at home and not at work, or vice versa. For instance, if you request us to contact you only at a specific address or telephone number, we will do so or we will make every effort to accommodate reasonable requests, and have an obligation to comply if you tell us that noncompliance may endanger you.
- You can inspect and copy the protected health information we have in our files. A statutorily set fee for copies may be charged for copies made by our office.
- You can request amendment of any inaccurate protected health information.
- On request, you can receive an accounting of the disclosures of protected health information that we have made.
- Even if you have agreed to receive privacy notices electronically, you can have, on request, a paper copy of any notice.

PRIVACY COMPLAINTS.

If you have a complaint about privacy matters, please let us know. You can make a complaint by writing or emailing our Privacy Officer, or filing in a form on our website. We will not retaliate against you in any way for making a privacy complaint.

You may also contact the Office for Civil Rights of the federal Department of Health and Human Services. You will find information about the HIPAA complaint procedure on their website (http://www.hhs.gov/ocr/privacyhowtofile.htm). You can call toll-free for assistance at: 1-800-368-1019.

CONTACT INFORMATION:

If you have any questions, or need further information, or wish to make a privacy complaint, please contact Kalyn Rodriguez [our Privacy Officer] as follows:

Fax Number: 619-435-4088

Email: drh.office447@gmail.com

Mail: 826 Orange Ave, #605, Coronado CA 92118

In Person: at the office during your scheduled appointment

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY:

I, ____*name*] have received a copy of the Privacy Policy of Richard Heidenfelder MD.

Date: ______________________

Signature: ______________________

Printed Name: ______________________