

**\*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 #  
\_\_\_\_\_

PHONE # \_\_\_\_\_

**A COPY OF YOUR DRIVERS LICENSE**

**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)

I HAVE READ AND UNDERSTAND THE OFFICE AND 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/ Dr. Heidenfelder will complete any necessary forms or letters that may be requested at his discretion. Lengthy forms or evaluations may incur additional fees.

     **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.



**Richard Heidenfelder M.D.**  
**Child/Adolescent and Adult Psychiatry**  
447 9<sup>th</sup> 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 ask 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 thought 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’s 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