M.C.L.A.
PSYCHIATRIC MEDICAL GROUP

IMPORTANT - PLEASE READ IMMEDIATELY

Your appointment with____________________________is at the location checked below:

☐ **MAIN OFFICE: 1560 E. Chevy Chase Drive, #130, Glendale, CA 91206**
Tel: (818) 240-0340, Fax: (818) 545-7672

☐ BURBANK OFFICE: 2211 W. Magnolia Blvd., #100, Burbank, CA 91506
Tel: (818) 240-0340

☐ ANNEX: 1487 E. Chevy Chase Drive, Glendale, CA 91206
Tel: (818) 240-0340

NAME:____

YOUR APPOINTMENT IS:________________________________ TIME____________

REQUIRED*: *YOU MUST CONFIRM YOUR APPOINTMENT –
To confirm your appointment, complete and return the following 4 forms to the ***MAIN OFFICE*** *at least 3 days before your appointment. If these forms are not received on time, the appointment will be cancelled. You may return the forms by mail (to the Main Office), fax (818) 545-7672, or email/scan to NewPatient@MCLApsych.com.*

1. **New Patient Information form** (included) – please complete ALL requested information which pertains to you and/or the patient. (If you belong to a medical group, be sure to include your Primary Care Provider's information.)
2. **Financial Agreement** (included) – This form must be signed by the person who has financial responsibility for the patient's care.
3. **Treatment Consent & Patient Confidentiality form** (included) – initial, sign and date this form.
4. **Completed Patient Treatment & Medical History form** (included); *sign and date form also*. This is very important information since it contains your past medical history. Please do not wait until you get to the office to fill this out.

BRING THE FOLLOWING ITEMS WITH YOU

1. **Insurance Cards** – **for BOTH primary and, if applicable, secondary insurance carrier cards**. Please provide the claims mailing address and phone number for your insurance company if they are not clearly marked on your card. Otherwise, we cannot file a claim for your service with your insurance company and you will be billed. If your card has a number for Mental Health Services, call for information regarding these services. Frequently mental health services are "carved out" to a different provider network.
2. **Photo ID**
3. **Authorization -** If you have an HMO, **you most likely will need an authorization.** Contact your insurer or medical group to ask if an authorization is required for *mental health services*. If an authorization is required and you do not have one when you arrive for your appointment, we will require full payment at the time of the visit. Most HMO plans will NOT pay any part of your visit when the required authorization was not obtained prior to the appointment. HMO rules are strict about this issue. If you do not have the required authorization you may choose to re-schedule your appointment. Please let the office know 24 hours in advance of the cancellation.
4. **COPAYs and DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE**.

(For payments of $25 and above, we gladly accept American Express, MasterCard, Visa, Discover and ATM cards.)

PLEASE ARRIVE 15 MINUTES EARLY

NEW PATIENT INFORMATION

PATIENT INFORMATION

Name:________________________ DOB:______________ ☐ Male ☐ Female

Street Address:________________________ Unit #:______ Primary Phone: (______)______________

City:________________________ State:______________ Zip Code:______________

Mailing Address (if different than above)________________________

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

Doctor's Name:________________________Tel :(________) ______________ Fax: (______)______________

FINANCIALLY RESPONSIBLE PARTY

Name:________________________ SS#:______________

Mailing Address:________________________ City:______________ State:________ ZIP:______________

Relationship to Patient:______________ Work Phone: (______)______________ Primary Phone: (______)______________

Driver's License #:______________ Employer:______________ Occupation:______________

PRIMARY INSURANCE INFORMATION

Policy Holder's Name:________________________ SS#______________

Relationship to Patient:______________ Employer:______________ Policy Holder's DOB:______________

Insurance:________________________ Subscriber's ID:______________ Plan #:______________

SECONDARY INSURANCE INFORMATION ☐ Check box if not applicable.

Policy Holder's Name:________________________ SS#______________

Relationship to Patient:______________ Employer:______________ Policy Holder's DOB:______________

Insurance:________________________ Subscriber's ID:______________ Plan #:______________

EMERGENCY CONTACT INFORMATION (a person not residing with you)

Contact Name:________________________ Relationship:______________ Tel: (______)______________

Nearest Relative or Friend (other than spouse or parent):________________________ Tel: (______)______________

FINANCIAL AGREEMENT

All professional services provided are charged to the patient or legal guardian unless there is an agreement with a third party payor (health plan, medical group, union, etc.).

1. Patients are personally responsible for co-payments, co-insurance, deductibles, percentages of charges when required by health plan, and/or all charges incurred if insurance coverage terminates or changes during the course of treatment.
2. **Co-payments and deductibles are due at the time of service.** For payment of $25 or more, MCLA accepts Visa, MasterCard, Discover, American Express, and ATM/debit cards.
3. If a check is returned by the bank, a fee of **$25.00** is added to the patient's account.
4. The patient is expected to know the amount of his or her financial responsibility regarding co-payments and deductibles. Call the number on the insurance card for this information. When calling the insurance company inform them you are calling about *mental health* benefits.
5. Late Cancellations and Missed Appointment Fees.

   Your appointment time is reserved only for you. If you are a new patient, the provider has reserved one hour of time for you. You must confirm this appointment by returning the required documents three (3) days prior to the appointment (unless other arrangements have been made). **If the documents are not received we will assume you do not intend to keep your appointment and it will be cancelled**.

   If you miss your appointment or cancel without providing staff with 24-hour notice, you will be charged the provider's full fee, which can be an amount anywhere from $150 - $400, depending on the level of licensure of your provider and the length of time reserved for your appointment.

   Please Note: To avoid the missed appointment / late cancellation charge, notify the office at least 24 hours in advance of your appointment. To cancel, call during business hours: 9a.m. -5 p.m., Monday through Friday. A voice mail message left after hours, weekends, or on holidays will NOT provide 24 hour notice for a next day cancellation. Health plans do not reimburse MCLA for missed sessions or late cancellations. Repeated "no shows" or late cancellations may result in referring you back to your health plan for reassignment to another practitioner outside of MCLA.
6. Reports and letters requested from your practitioner utilize the time of your practitioner and the office staff. **The most efficient way to have forms completed is during your session as the practitioner can discuss the issues with you**. There is a charge for forms and letters and the fees vary depending on the complexity of the request, with the minimum charge being $15.00**.** With complex letters, reports, and forms such as evaluations for private disability, your charge may be as much as $400. Most health plans do not cover these fees and arrangements for payment are made at the time of the request.
7. In the event a patient's overdue account must be submitted to a collection agency or legal action should become necessary to collect any unpaid balance, the patient is responsible for collection, attorney, and court costs.
8. A copy of this assignment is as valid as the original.

I have read the above information. By typing my name below, I agree to accept the financial fYsponsibilities for myself or for the dependent if I am the legal representative.

Patient / Responsible Party Signature

Date

Patient / Responsible Party's **Printed** Name

TREATMENT CONSENT & CONFIDENTIALITY

EMERGENCIES: If you have an emergency situation during business hours call 818-240-0340. After hours, your clinician is available by calling 818-240-0340 and following the prompts. If you are in imminent danger, call 911 or go to the nearest hospital emergency room.

My INITIALS in the boxes and SIGNATURE below indicate that I have read and understand the following procedures.

INITIAL BELOW	FORM TO BE COMPLETED BY PATIENT (OR PARENT / GUARDIAN IF PATIENT IS UNDER THE AGE OF 18)
______ *INITIALS*	**Confidentiality:** To protect your best interests and personal rights, please be aware that professional ethics and law dictate whatever you say to your psychotherapist or psychiatrist (your Protected Health Information or PHI) will remain confidential and will not be shared with anyone without your written permission. The following are exceptions to this confidentiality and may be clarified with your Practitioner. 1. If you indicate that you intend to harm yourself or anyone else your Practitioner must take reasonable and precautionary measures to protect whoever is in danger. 2. If you report to your Practitioner any knowledge of child, elder, or dependent abuse, your Practitioner may be required by law to report it to the authorities or child protective services. 3. If you are under the age of 18, your parents or legal guardians have the right to be informed of your psychological condition, progress, and treatment goals. 4. Brief written records are kept regarding your treatment goals and progress. Certain situations may arise where the records are subpoenaed by a lawyer or judge. We may be compelled to surrender them. This may occur when you become involved in a legal situation in which your psychological state is an issue. Practitioners subpoenaed to appear in court require payment for their professional services prior to the court date, including travel time.
______ *INITIALS*	**Consent for Treatment:** I authorize treatment for myself or the dependent indicated as the patient. *If the patient is a minor, I have the legal authority to authorize treatment.* 1. I understand my Practitioner will discuss my individual treatment with me; together we will revise my treatment plan as necessary. 2. I authorize my behavioral health Practitioner to carry out psychological examinations, treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. 3. I understand that while the course of my treatment is designed to be helpful, it may at times be difficult and uncomfortable.
______ *INITIALS*	**Release of Information to the Health Plan:** I understand that if my behavioral healthcare Practitioner requests authorization for additional sessions from my managed care company, the medical necessity for further treatment and the effectiveness of treatment already provided will be weighed. 1. I authorize MCLA to release the required information in order to process claims with my payor. I authorize payment of psychological / mental health benefits to MCLA for the professional services rendered.
______ *INITIALS*	**Coordination of Care between MCLA Practitioners:** If I am under treatment with more than one MCLA Practitioner, I authorize communication regarding my treatment between my MCLA Practitioners.
______ *INITIALS*	**Courtesy Call:** I authorize my healthcare provider to use an automated telephone system and to use my name, the name of my scheduled treating healthcare provider, and the time of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited PHI regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine. *I understand that a call to remind me of an appointment is only a courtesy provided by MCLA. Any failure by the automated phone system to provide the courtesy call does not relieve me of my responsibility to either keep my appointment or call the office during business hours (9 a.m. – 5 p.m., Monday – Friday) to cancel my appointment with 24-hour notice. Failure to cancel with 24 hour notice will result in a charge. Please note: A voice mail message left after hours, weekends, or holidays will NOT provide 24 hour notice for a next day cancellation.*
______ *INITIALS*	**Release of my Protected Health Information:** I authorize my behavioral healthcare Practitioner to communicate the above-mentioned PHI, in accordance with my "Notice of Privacy Practices", in person, by telephone, by written material, e-mail, or by facsimile. I understand that MCLA cannot be held responsible for maintaining confidentiality *once my PHI leaves the office*. I release the source of these records from any liability arising from their release.
______ *INITIALS*	**Appeals and Grievances:** I understand that I have the right to formally appeal decisions regarding authorized treatment services by first contacting MCLA. I further understand that I have the right to submit a complaint or grievance to MCLA regarding any aspect of my care, or I may submit complaints to my health plan. I understand that I risk nothing in exercising these rights.
______ *INITIALS*	**Revocation of Consent:** I understand that this authorization is subject to revocation by me at any time except to the extent that action has been taken in reliance hereon and that a photocopy of this release is to be considered as valid as the original.
______ *INITIALS*	**Notice to Consumers:** I have been informed the Medical Board of California licenses and regulates medical doctors. Tel: (800) 633-2322 www.mbc.ca.gov
______ *INITIALS*	**I hereby acknowledge that I have been provided a copy of MCLA Psychiatric Medical Group's "Notice of Privacy Practices". (Included in this packet.)**

I understand and agree to the above.

Patient / Legal Guardian Signature: ______________________________

Patient / Legal Guardian (please print):______________________________ **Date:**__________________

PATIENT TREATMENT & MEDICAL HISTORY

GOALS FOR TREATMENT

- ☐ Depression
- ☐ Anxiety
- ☐ Controlling Stress
- ☐ Loss of Loved One
- ☐ Problems at School
- ☐ Problems at Work
- ☐ Lack of Friends
- ☐ Loneliness
- ☐ Problems Coping
- ☐ Abuse / Victimization
- ☐ Finance Problems
- ☐ Legal Matters
- ☐ Marriage / Relationship Problems
- ☐ Sexuality / Sexual Issues
- ☐ Family Conflict
- ☐ Behavioral Problems
- ☐ Eliminating a Drug / Alcohol Habit
- ☐ Eliminating Another Habit (overspending, overeating, gambling, etc.)
- ☐ Other:____________________

MEDICAL HISTORY

Date of last physical exam:____________________

Significant findings, if any:____________________

Current prescription medication and over the counter medication (dosage, frequency):____________________

Known allergies / medication allergies:____________________

Current and previous medical illnesses and hospitalizations:____________________

FAMILY HISTORY

Does anyone in your immediate family have a history of serious illness? If yes, please explain:____________________

Please list any medical, psychological or chemical dependency family history, including suicide or homicide attempts:____________________

Describe any abuse / victimization to yourself or any person in your family:____________________

CHEMICAL USE / ABUSE HISTORY (if not applicable, please mark box: ☐)

SUBSTANCE	C= Current P= Past	AMOUNTS / FREQUENCY	TIME PERIOD USED	DATE LAST USED	WHAT KIND OF TREATMENT?
Alcohol					
Marijuana					
Cocaine / Speed					
Prescription Drug Abuse					
Cigarettes					
Other:					

MENTAL HEALTH TREATMENT

NAME OF PROVIDER / PROGRAM / HOSPITAL	DATES	# OF SESSIONS	DID IT HELP?

LEGAL PROBLEMS / ARRESTS:____________________

____

Patient / Legal Guardian Signature

____________________ ____________________

Patient / Legal Guardian Name **Printed** Date

NOTICE OF CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION (PHI)

THE INFORMATION BELOW DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The federal regulations, known as the Health Insurance Portability and Accountability Act (HIPAA), are designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians and other health care practitioners, hospitals, and health plans. Clinicians must comply with the privacy rule's standards for protecting the confidentiality of your health information.

These regulations protect virtually all patients regardless of where they receive their health care. Every time you see a physician or other healthcare provider, or are admitted to a hospital or other healthcare facility, the privacy rule is in effect. All health information, including paper records, oral communications, and electronic formats (such as e-mail), is protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, these rights are not absolute and *there are exceptions in mental health*. Precautions are taken in this office to safeguard your health information such as training of employees and the employing of computer security measures. If applicable, feel free to discuss with the Office Manager any concerns you may have concerning exercising your rights or how your health information is protected.

This "Notice of Privacy Practices" explains the privacy practice for this office. It contains very important information about how your confidential health information is handled. It also describes how you can exercise your rights with regard to your protected health information.

Uses and Disclosures of Health Information:
We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health and safety purposes, for auditing purposes, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization to disclose information; you can later revoke that authorization to stop any future uses and disclosure.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the Office Manager.

Individual Rights:
In most cases, you have the right to look at or get a copy of health information that we use to make decisions about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other instances than when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints:
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the Office Manager. You may also contact the U.S. Department of Health and Human Services.

Office of Civil Rights
US Dept. of Health & Human Services
50 United Nations Plaza, Room 322
San Francisco, CA 94102
Tel: (415) 437-8310 Fax: (415) 437-8329

Our Legal Duty:
We are required by law to protect the privacy of your information, provide you with this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

OFFICE MANAGERS: *Glendale:* Everly Sahagun, Tel: 818-240-0340, ext. 101 / *Burbank:* Crystal Campos, Tel: 818-240-0340, ext. 200

NOTICE TO HEALTHCARE CONSUMERS

The Medical Board of California licenses and regulates medical doctors. Tel: (800) 633-2322 www.mbc.ca.gov

NOTICE OF PATIENT'S FINANCIAL RESPONSIBILITIES

All professional services provided are charged to the patient or legal guardian unless there is an agreement with a third party payor (health plan, medical group, union, etc.).

- Patients are personally responsible for co-payments, co-insurance, and deductibles, when required by health plan, and/or all charges incurred if insurance coverage terminates or changes during the course of treatment.
- **Co-payments and deductibles are due at the time of service**. A $5.00 service charge may be added if you are billed for the amounts due at the time of your appointment.
- If a check is returned by the bank, a fee of **$25.00** is added to the patient's account.
- The patient is expected to know the amount of his or her financial responsibility regarding co-payments and deductibles. Patients can call the number on the insurance card for this information. Indicate you are calling for *mental health* benefits.
- **Missed appointments and late cancellations.** Your practitioner reserves your appointment only for you. To avoid the missed appointment / late cancellation charge of the provider's **full fee,** notify the office at least 24 hours in advance of your appointment (business hours are 9 a.m. – 5 p.m., Monday – Friday. A voicemail message left after business hours, on weekends, or over holidays will not provide 24 hour notice for a next day cancellation. **(Please note:** The full fee charge can range from $150 to $400 depending on your provider's level of licensure and the amount of time reserved for your appointment.) Your insurance will not pay for a missed appointment.
- Reports and letters requested from your practitioner utilize the time of your practitioner and the office staff. There is a fee for such items and the fees vary depending on the complexity of the request with the minimum charge being **$**15.00 and a maximum of $400 for complex forms and letters**. Most health plans do not cover these fees and arrangements for payment of report and letter fees are made at the time of the request.**
- In the event a patient's overdue account must be submitted to a collection agency or legal action should become necessary to collect any unpaid balance, the patient is responsible for collection, attorney, and court costs.
- A signed COPY of the *Financial Responsibilities Agreement* is as valid as the original.

KEEP THIS PAGE FOR FUTURE REFERENCE

NOTICE TO CONSUMERS

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

Lukas Alexanian, MD
Physician and Surgeon
Board Certified
General Psychiatry
American Board of Psychiatry and Neurology

I. Marius Campeanu, MD
Physician and Surgeon
Board Certified
General Psychiatry
American Board of Psychiatry and Neurology

Inessa Essaian, MD
Physician and Surgeon
Board Certified
General Psychiatry
American Board of Psychiatry and Neurology

David E. Estrada, MD
Physician and Surgeon
Board Eligible,
General Psychiatry
Child and Adolescent Psychiatry

Kevork K. Iskenderian, MD
Physician and Surgeon
Board Certified
American Board of Psychiatry and Neurology
General Psychiatry
Subspecialty, Child and Adolescent
Psychiatry

Robert D. Rosenberg, MD
Physician and Surgeon
Board Eligible
General Psychiatry

Karina Shulman, MD
Physician and Surgeon
Board Eligible
General Psychiatry

Abigail M. Stanton, MD
Physician and Surgeon
Board Certified
General Psychiatry
American Board of Psychiatry and Neurology

Irena S. Westmoreland, MD
Physician and Surgeon
Board Eligible
General Psychiatry

Linda L. Woodall, MD
Physician and Surgeon
Board Certified
American Board of Psychiatry and Neurology
Subspecialty, Child and Adolescent
Psychiatry