

Thuy D. Rotunda, M.D.
1100 Quail Street • Suite 206 • Newport Beach, CA 92660
Tel/Fax: 949-608-9659 • www.newportpsych.com
Email: dr.rotunda@newportpsych.com

Child/Adolescent Patient Information (< 18 years old)

Name _____ DOB _____ Age _____

SS# _____ Sex _____

Phone (Cell) _____ Can a message be left at this number? yes no

Child's current school _____ Grade _____

Ages that child: Crawled _____ Walked _____ Talked _____ Potty Trained _____

Legal Guardian #1

Legal Guardian #2

Name: _____

Relationship
To Patient: _____

Who currently has legal custody of this child? _____

Siblings

Name _____	Age _____	Sex _____
Name _____	Age _____	Sex _____
Name _____	Age _____	Sex _____

Referral Source _____

In case of Emergency Contact:

Name _____ Relationship _____
Phone _____

Signature _____

Print Name _____ Date _____

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Mother's Information:

Name _____ SS# _____
Address _____
City _____ State _____ Zip _____
Phone (home) _____ Can a message be left at this number? yes no
noPhone (work) _____ Can a message be left at this number? yes no
Phone (cell) _____ Can a message be left at this number? yes no
Email _____
How do you prefer to be contacted? _____

DOB _____ Age _____ Race _____ Religion _____

Marital Status _____ Spouse (if married) _____
Educational background _____
Occupation _____
Employer _____
Address _____

Father's Information:

Name _____ SS# _____
Address (if different from above) _____
City _____ State _____ Zip _____

Phone (home) _____ Can a message be left at this number? yes no
Phone (work) _____ Can a message be left at this number? yes no
Phone (cell) _____ Can a message be left at this number? yes no
Email _____
How do you prefer to be contacted? _____

DOB _____ Age _____ Race _____ Religion _____

Marital Status _____ Spouse (if married) _____
Educational background _____
Occupation _____
Employer _____
Address _____

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Health Questionnaire

Pediatrician/Family Physician: Address: Phone: Last physical:	Current Medications: <u>Name:</u> <u>Dosage:</u> ----- ----- -----
Have child ever been hospitalized in a psychiatric/rehab facility? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, how many times _____ Hospital: year: ----- ----- -----	Has child ever had: Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/> High Blood Pressure Yes <input type="checkbox"/> No <input type="checkbox"/> High Cholesterol Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Disease Yes <input type="checkbox"/> No <input type="checkbox"/> Thyroid disease Yes <input type="checkbox"/> No <input type="checkbox"/> Seizures Yes <input type="checkbox"/> No <input type="checkbox"/> Other major illnesses/accidents/surgeries? ----- -----
Is anyone on either side of child's family ever had: (please circle) Depression, anxiety, schizophrenia, bipolar, ADD/ADHD, attempted/completed suicide, drugs/alcohol, diabetes, high blood pressure, high cholesterol, heart disease, cancer, seizure, thyroid problems	Past psychotherapy/counseling: <u>Name:</u> <u>treatment dates:</u> ----- ----- -----
Allergies to medications	Past psychiatric outpatient treatment: <u>Name:</u> <u>treatment dates:</u> ----- ----- -----
Any problems during prenatal/perinatal period? ----- -----	
Cigarettes/Alcohol/Drug? How much? ----- ----- -----	

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Office Policies

MEDICATION REFILLS

I do not refill medications without seeing a patient in session. Please do not contact your pharmacy to request refills. Please contact me directly with questions or concerns about medication supply and I will call the pharmacy if needed. If you missed an appointment, you will be given enough medication to last until our next rescheduled session, usually within 2 weeks.

FEES

My fee is **\$500** for an initial 1.5 to 2 hour assessment. **\$300** for a fifty minute session and **\$175** for a twenty-five minute session. **I do not spend more than 10 minutes speaking on the phone;** any matter taking longer than that needs to be discussed during a session. If I do spend more than 10 minutes talking on the phone, or doing other services such as report writing, preparation of documents, or any other services you may request, the entire time will be charged prorated based on \$300 per 50 minutes. Fees may be subject to change, in which case you will be notified in advance.

CANCELLATIONS AND NO-SHOW POLICY

If you do not provide at least 24 business hours notice, or fail to show for a scheduled appointment, you will be responsible for the full cost of the session.

INSURANCE REIMBURSEMENT

I am not on any insurance plans, and am considered an “out of network provider” for PPO plans. All charges are your responsibility, whether or not you have insurance. I will provide you with a statement that can be submitted to your insurance company.

PAYMENTS

Payment for services provided is due at the end of each session. If your account has payment overdue for over 60 days, legal means will be considered to secure payment, including collection agencies. There will be a \$25.00 service charge for all returned checks.

CONTACTING ME

All calls to my office number are answered by voice mail and will be returned by the next business day. For urgent psychiatric issues you can press “1” during the voicemail to be directed to my cell phone. I will make every effort to answer my cell phone on these occasions; if I am unable to, I will return your call as soon as possible. **Please reserve calling my emergency line only for truly emergency cases.** You are welcome to email me, but I do not check for messages as regularly as I do with telephone messages, and therefore, I cannot guarantee that I will respond to email messages in a timely manner. Please be aware that email is not a secure medium.

PATIENT RECORDS

Both the law and the standards of my profession require that I keep appropriate treatment records. You are entitled to review a copy of the records, unless I believe seeing them would be emotionally damaging, in which case, I will be happy to provide them to an appropriate mental health professional of your choice. I can also prepare an appropriate summary.

CONFIDENTIALITY

Confidentiality is of utmost importance in mental health treatment and is protected by the law. There are exceptions to confidentiality where disclosure is required by law. These are:

- Threat of harm to self
- Threat of harm to others
- Inability to care for your basic needs (food, clothing, shelter)

Initial _____

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- Indication of possible abuse to a child, elderly person, to disabled person

In the event of any of the above, I may have to contact other parties (ie. family members, state agency, police, or hospital) in order to protect you or someone else.

PRACTICE STATUS

I share an office suite with other mental health professionals. With regard to your clinical care, I am completely independent and solely responsible. My clinical records are separately and securely maintained.

I have read and understand all the information above. I agree to evaluation and/or treatment by Dr. Thuy Rotunda, that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

Patient name: _____

Name of responsible party (if other than patient): _____

Signature of patient/responsible party: _____ Date: _____

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Credit Card Authorization

Dear Patient/Parent:

Your appointment is set for you; in return, you will be asked for a credit card number and the information will be held securely. This account can be used to pay for regular sessions or only for conditions listed below. It may be a convenience to you not to have to write checks. This also helps to eliminate time and resources needed to pursue payment for overdue balances.

Payment is required for all services at the time they are rendered.

If you must cancel or reschedule an appointment, please do so at least 24 hours before the scheduled appointment time. You will be charged the full fee if you fail to show up for your appointments and do not notify my office 24 hours in advance.

your credit card will not be charged unless one of the following conditions apply:

- no-show for a scheduled appointment
- cancellation less than 24 business hours in advance
- participation in treatment (eg. appointment or phone session) without payment rendered.

Thank you for your cooperation.

Sincerely yours,
Thuy Rotunda, M.D.

I, _____ authorize Thuy Rotunda, M.D., to charge my credit card if I fail to show for an appointment, for cancellations with less than 24-hour notice, and for any outstanding balance on my account. I will not dispute charges for sessions I have received or that I have not cancelled less than 24 business hours in advance. I further authorize Dr. Rotunda to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

credit card (circle one):

Visa Mastercard American Express

Account number _____ Expiration Date _____

Billing Address _____

Verification/Security Code (3-digit code on back; for Amex card, 4 digit code on front) _____

Name on card (please print) _____

Signature _____ Today's Date _____
(patient or financially responsible person)

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Authorization of Use/Disclosure of Health Information

(Please use this form to provide consent to allow Dr. Rotunda to contact people who may be helpful in your care – your therapist, physicians, family or friends)

Patient Name _____ DOB _____

Authorization is given to Thuy Rotunda, M.D. to exchange information with:

Name	Address	Phone/Fax

Information to be disclosed:

The information that is disclosed may include any/all of your health information that Dr. Rotunda has in her possession, including information relating to any medical history, mental or physical condition and any treatment received, including drug, alcohol or other controlled substance, billing information, correspondence, and records obtained from other health care providers.

You may limit the information to be disclosed. In this case, indicate the following records or types of health information that may be disclosed (insert dates of treatment, types of treatment or other designation):

Name of responsible person

Relationship to patient

Signature

Date

Witness: Thuy D. Rotunda, M.D. Date

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HIPAA Notice of Privacy Practices

I. 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.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. This notification takes effect **April 14, 2003** and will remain in effect until replaced.

PHI is used when I share, apply, utilize, examine, or analyze information *within* my practice.

PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party *outside* my practice.

With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations that *Do Not Require Your Prior Written Consent*. I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychologist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples:

Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get your claim processed for the health care services that I have provided to you.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures *Do Not Require Your Consent*. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

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4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.

8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

13. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

14. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

15. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.

16. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

17. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. You will receive a response from me within 30 days of my receiving your written request. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I

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do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. Right to an Accounting: You generally have the right to receive a list of disclosures of PHI for which you have neither authorization nor consent (see above for this section). This accounting will begin on 4/15/03 and disclosure records will be held for six years. On your request, I will discuss with you the details of the accounting process.

E. The Right to Amend Your PHI. If you believe that your PHI is incorrect or incomplete, you may ask me to amend the information. This request must be made in writing, and it must explain why the information should be amended. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. Questions and Complaints

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with me. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

Contact Information:

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I have received a copy of the notice of HIPAA privacy practices.

NOTICE TO CONSUMERS

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

Name of patient or responsible party

Relationship to patient

Signature

Date