Thuy D. Rotunda, M.D.
1000 Quail Street • Suite 155 • Newport Beach, CA 92660
Tel/Fax: 949-608-9659 • www.newportpsych.com
Email: dr.rotunda@newportpsych.com

Patient Information

Name_____SS#_____

Address_____ Age_____DOB_____

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?_____

Religion_____ Race_____Gender_____

Marital Status_____Spouse (if married)_____

Educational background_____

Occupation_____

Employer_____
Address_____

Referral
Source_____

Family/friends to contact in case of **Emergency:**

Name_____Relationship_____
Phone_____

Name_____Relationship_____
Phone_____

Signature_____ Date_____

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Health Questionnaire

Primary Care Physician:

Address:

Phone:
Last physical:

Current Medications:
Name: Dosage:

Have you ever been hospitalized in a psychiatric/rehab facility? Yes ☐ No ☐

If yes, how many times _____

Hospital: year:

Have you ever had:

Diabetes Yes ☐ No ☐
High Blood Pressure Yes ☐ No ☐
High Cholesterol Yes ☐ No ☐
Heart Disease Yes ☐ No ☐
Thyroid disease Yes ☐ No ☐

Other major illnesses/accidents/surgeries?

Is anyone on either side of your family ever had: (please circle)

Depression, anxiety, psychosis, bipolar, ADD/ADHD, attempted/completed suicide, drugs/alcohol, diabetes, high blood pressure, high cholesterol, heart disease, cancer, seizure, thyroid problems

Past psychotherapy/counseling:

Name: treatment dates:

Allergies to medications:

Do you use:

Cigarette: ☐ No ☐ yes
Caffeine: ☐ No ☐ yes
Alcohol: ☐ No ☐ yes
Marijuana: ☐ No ☐ yes

Other substance/drug use:

Past psychiatric outpatient treatment:

Name: treatment dates:

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Office Policies

I look forward to working with you to provide the best mental health care for you, your child, or your family. In order to prevent any misunderstanding concerning your psychiatric care, including contact in between sessions, cancellation policy, responsibility for payment for services provided, please read the following information carefully:

EVALUATION AND TREATMENT

The initial step in our work is the evaluation to clarify what the problems are and what treatment would be best for you. After the initial assessment, we will discuss the risks and benefits of treatment options versus no treatment. We could decide to proceed with therapy or medication treatment, or a combination of both. If you feel it is not possible for us to work together for any reason, I will do my best to refer you to other mental health clinicians better suited for your needs.

MEDICATION REFILLS

I do not refill medications without seeing a patient in session. You will be given enough medication to last until our next appointment. Please do not contact your pharmacy to request refills as I do not approve refill requests made by pharmacies. Any decisions about medications and your health will be made between you and me. Please contact me with questions or concerns about medication supply. If you missed or could not make an appointment, you will be given enough medication to last until our next rescheduled session, usually within 2 weeks. This is done to ensure the safe and effective use of medications.

FEES

My fee is **$400** for an initial 1.5 to 2 hour assessment (regardless of whether it is for therapy, medications or both), **$260** for a fifty minute therapy session with or without medication treatment, and **$160** for a twenty-five minute session. Any other professional services that require longer than 10 minutes such as report writing, telephone conversations, preparation of documents, or time spent performing any other services you may request will be charged **$50** for each 10-minute increment. Fees may be subject to change, in which case you will be notified in advance.

CANCELLATIONS AND NO-SHOW POLICY

Once your appointment is scheduled, you will be expected to pay for it unless you provide at least **24 business hours** advance notice of cancellation. 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 companies will often not reimburse for missed sessions or sessions cancelled late.

INSURANCE REIMBURSEMENT

I am not on any insurance plans, and am considered an “out of network provider” for PPO plans. Please be aware that your health insurance policy is an agreement between you and your insurance company. 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. Please find out from your insurance company exactly what mental health benefits are covered.

PAYMENTS

Payment for services provided is due at the end of each session, unless we agree otherwise. If your account has payment overdue for over 60 days, legal means will be considered to secure payment, including collection agencies or small claims court. There will be a $25.00 service charge for all retuned checks.

Initial _____

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CONTACTING ME

All calls to my office number are answered by voice mail. I do check for messages frequently throughout the day, even on weekends, and return phone calls by the next business day. For urgent psychiatric issues that you need to speak to me right away, 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 you call as soon as possible. Please reserve calling my emergency line only for truly emergency cases, as you might be interrupting a session. If I will be unavailable for an extended period of time, I will provide you with the name of a trusted colleague whom you can contact if necessary. 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. Because these are professional records, they can be misinterpreted or upsetting, so I recommend that we review them together so that we can discuss what they contain. I can also prepare an appropriate summary for review.

CONFIDENTIALITY

Confidentiality is of utmost importance in mental health treatment and is protected by the law. I can only release information about our work to others with your written permission. For child and adolescent patients, their trust in me is paramount. Before discussing a sensitive issue with the parent I will first get the minor's permission. I generally try to help the child/adolescent to discuss any sensitive matters with their parents themselves.

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)
- 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:

If you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

I have implemented a similar policy. Your appointment is set for you; in return, you will be asked for a credit card number at the time you check in 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.**

Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 business hours in advance, or 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 car 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): _____

Name on card (please print) _____

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

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(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)

Authorization of Use/Disclosure of Health Information

Patient Name_____ DOB_____

I hereby authorize Thuy Rotunda, M.D. to: *release and receive* / *receive* / *release* information to/from:

Name _____
Adress_____
Phone_____Fax_____

Information to be disclosed:

☐ All of my health information that Dr. Rotunda has in her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance, billing information, correspondence, and records from my other health care providers that Dr. Rotunda may have.

☐ All of my health information described above except for the following:

_____

☐ Only the following records or types of health information (insert dates of treatment, types of treatment or other designation):

_____

This consent authorizes verbal discussion of information and exchange of written information. This consent is valid for one (1) year from the date of signature, unless revoked earlier.

_____ _____
Name of responsible person Relationship to patient

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

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PATIENT PARTNERSHIP PLAN

Dear Patient,

I would like to welcome you to my practice. I intend to provide you, your child, or your family with the care and service you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and me as your doctor. As my "partner in health", I ask you to help me in the following ways:

Keep Follow-up Appointments and Reschedule Missed Appointments
Returning to my doctor on time gives her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might change my medications, order tests, refer me to a specialist, or even discover a serious health condition. If I miss an appointment and do not reschedule, I run the risk that Dr. Rotunda will not be able to adequately treat my condition or stabilize me when my condition worsens, or detect a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Check In With Brief Phone Contacts
I understand that Dr. Rotunda will want to know how my condition progresses after I leave the office. Especially at the beginning of a trial of new medication, it is important that we keep in touch in between sessions. I understand that when I start a new medication, I may experience unpleasant side effects and that letting Dr. Rotunda know how I am responding to treatment is the best way to care for my condition. I will call in with an update on how I am responding to treatment, at the agreed upon time in between our sessions. I will also call in and let Dr. Rotunda know at any time I have a symptom that is concerning me.

Follow Up With Specialists
I understand that at times, Dr. Rotunda will want me to see a specialist to assist in my treatment. It may be a therapist for psychotherapy, a primary care doctor or a specialized physician to address a medical concern, or even to get a blood test. I understand that if an important part of my emotional or physical wellbeing has been negatively affected and is not addressed, it can adversely impact my health and/or interfere with my treatment with Dr. Rotunda.

Inform My Doctor If I Decide Not To Follow Her Recommended Treatment Plan
I understand that after evaluating me, my doctor may make certain recommendations based on what she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs, or even asking me to return to the office within a certain period of time. I understand that ***not*** following my treatment plan can have serious negative effects on my health. I will let Dr. Rotunda know whenever I decide ***not*** to follow her recommendations so that she may fully inform me of any risks associated with my decisions to delay or refuse treatment.

Thank you for your partnership. As my patient, you have the right to be informed about your health care. I invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask me.

_____	_____	_____
Patient Signature	Date	Dr. Rotunda's Signature

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HIPAA Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOWYOU 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 heath-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

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 or 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**.**

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

_____	_____
Name of patient or responsible party	Relationship to patient
_____	_____
Signature	Date