Pacific Coast Psychiatric Associates

490 Post St. #1039 & 939
San Francisco, CA 94102
PH: 415-296-5290

2970 Camino Diablo, 1st & 3rd Flr
Walnut Creek, CA 94597
www.pcpasf.com

6200 Wilshire Blvd #1010 & 1410
Los Angeles, CA 90048
FAX: 415-296-5299

NEW PATIENT REGISTRATION FORMS

- Please complete this form in its entirety. No further paperwork will be required at your initial appointment.
- Page 2 asks for your primary care provider's contact information (if you are currently seeing one). This is required so that your PCPA psychiatrist can collaborate with them as appropriate. If you do not have their full contact information, please obtain it via web search.
- Page 3 explains our payment policy and Patient Portal.

PATIENT DEMOGRAPHIC INFORMATION

FIRST NAME:_____ LAST NAME:_____
DATE OF BIRTH:____/____/_____ (MM/DD/YYYY) SEX:_____
ADDRESS:_____ CITY:_____
STATE:_____ ZIP:_____ CELL PHONE: (_____)-_____-_____
EMAIL ADDRESS:_____

EMERGENCY CONTACT: _____
RELATIONSHIP:_____
EMERGENCY CONTACT PHONE NUMBER :(_____)-_____-_____

INSURANCE INFORMATION

PLEASE REFER TO YOUR INSURANCE CARD FOR THE FOLLOWING INFORMATION

INSURANCE CARRIER: _____ INSURANCE ID: _____

INSURANCE PHONE NUMBER: (_____)-_____-_____

DO YOU HAVE MEDICARE OR MEDI-CAL? _____

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

At PCPA, we understand the importance of collaboration with other members in our patients' treatment team. We therefore ask that you take a minute to provide us with their contact information and sign the Consent for Release of Information.

PATIENT NAME:_____ DOB:_____

PRIMARY CARE PROVIDER INFORMATION

NAME: _____ ADDRESS: _____ SUITE:_____

CITY: _____ STATE: _____ PHONE: _____

ADD ANOTHER PROVIDER (if any)

PROVIDER TYPE: _____

NAME: _____ ADDRESS: _____ SUITE:_____

CITY: _____ STATE: _____ PHONE: _____

I understand that only the patient who has consented for care (including minors 13 years of age and older) can authorize for release of records. I understand that these records may contain information relating to psychiatric/mental health, HIV/AIDS, sexually transmitted diseases, and/or drug/alcohol abuse. I give my specific authorization for these records to be released. I understand that authorizing the disclosure of this health information is voluntary. I do no need to sign this form in order to assure treatment or payment. I understand that I can cancel this authorization at any time by writing to PCPA, 490 Post St. #1043, SF CA 94102. I understand that once the information has been released according to the terms of this authorization, that the information cannot be recalled. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules. I may cancel this authorization at any time, except to the extent that action has already been taken. To revoke Authorization to Release Patient Health Information, I must do so in writing. Unless I cancel earlier, this authorization will expire when treatment with PCPA has ended or one year after date of last visit. Further, I understand that a copy of this document may be faxed or mailed to the above providers

PATIENT SIGNATURE: _____ DATE: _____

To Providers: This document is for your records. Please do not send any patient records until specifically requested. Thank You.

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ACKNOWLEDGMENT SIGNATURE FORM

☐ ***Authorization to release patient health information for treatment, billing or healthcare operations. (Available to view and print on our website)***

☐ ***Acknowledgement of receipt of Notice of Privacy Practices and Policies from Pacific Coast Psychiatric Associates. (Available to view and print on our website)***

☐ ***Acknowledgment of receipt of Office Policies and Procedures from Pacific Coast Psychiatric Associates. (Available to view and print on our website)***

PAYMENT POLICY

☐ ***I understand that payment is due at the time of each service by credit card. Please note that this includes CoPayments, CoInsurance and Deductibles.***

☐ ***If we contract with your insurance company, we will submit statements directly to the insurer on your behalf, but if any amount is declined or applied to your deductible, we will bill you the unpaid amount. I agree to make payment by the next appointment, or within 30 days if there is no appointment scheduled before.***

☐ ***If there is any amount owed to us for any reason that remains unpaid after 60 days from the date first billed, you authorize us to charge this amount to your credit card on file without further notice.***

☐ ***The Credit card on file will be automatically charged a $175.00 fee for any late cancellations (less than 48 business hours notice) or no-shows, with no exceptions.***

PATIENT PORTAL

☐ ***I understand that information submitted via the portal will NOT BE REVIEWED UNTIL MEETING IN PERSON WITH MY DOCTOR. I will therefore contact my provider directly for any urgent matters.***

☐ ***I have reviewed this form and I agree with all policies and procedures as described above.***

Patient Printed Name_____

Patient Signature_____ Date _____

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Important Information

● Please also note that PCPA has a 48 business hours cancellation policy. Once your appointment is scheduled, your will be charged $175 if you fail to cancel your appointment with adequate notice or do not show up to your appointment.

● Please try to arrive to your appointment on time. Your first appointment will be about 45 minutes in duration. Please note that if you arrive late, the appointment time cannot not be extended as your psychiatrist or therapist has a full schedule.

● Please note that the entire evaluation may not be completed in just one session. You and your psychiatrist or therapist will schedule a second session to complete the evaluation if necessary.

● During psychiatric evaluations, your psychiatrist will ask you about current and past psychiatric symptoms, Mental Health treatment history, current medication regimen, history of Alcohol and Drug use and about any current stressors you might be dealing with. At the end of the evaluation process, your psychiatrist will provide you with feedback, including their thoughts about a diagnosis as well as treatment recommendations.

● Please note that although all of our psychiatrists do provide psychotherapy treatment, depending on their caseload at the time of your evaluation, they may not be able to provide you with psychotherapy themselves. If that is the case, they will provide you with the appropriate referrals.

● Please also note that your psychiatrist may not be able to prescribe you medication on the first visit. Prescribing psychiatric medications on the first visit will be evaluated by your psychiatrist on a case by case basis. If that is a concern of yours, please bring this up when you first see your psychiatrist.

I have read and agree to the above policies and procedures: _____ (your initials)

PLEASE MAIL OR FAX THIS FORM AND WE WILL CONTACT YOU TO SCHEDULE AN APPOINTMENT. We look forward to meeting with you and providing you with excellent service!