CLARITY
MENTAL HEALTH

New Patient Basic Information

Name: _____ Social Security Number: _____

Date of birth: ___/___/_____ Gender: ☐ M ☐ F

Home Address

Street: _____

City: _____ State: _____ Zip: _____

Contact Information

Home phone: _____ Work phone: _____

Cellular phone: _____ Email address: _____

Would you prefer email, phone call, or text reminders? _____

Which number/email should the reminder be sent to?_____

Emergency Contact

Name: _____ Phone number: _____

Your Preferred Pharmacy – So we can call or send in prescriptions electronically

Name: _____ Phone Number: _____

Address: _____

Insurance – Although we do not accept insurance directly, this information helps us with choosing medications in your plan's formulary and providing any necessary documentation.

Plan name: _____

Will you be requiring a superbill to request reimbursement from your insurance company? YES/NO

Clarity Mental Health
595 E. Colorado Blvd, Suite 505, Pasadena, CA 91101
Tel: (626) 869-7338, Fax: (626) 869-7383

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New Patient Basic Information (continued)

How did you hear about us?

What are your goals for treatment?

Please list any medication allergies and reactions:

Please list your current medications:

Please note any medical problems you may have:

Please list your primary care provider and contact information:

Name: _____ Phone number: _____

May I discuss your care with your primary care provider? ☐ Yes ☐ No

If you have a therapist and would like to leave their name and contact information:

Name: _____ Phone number: _____

May I discuss your care with your therapist? ☐ Yes ☐ No

_____ _____ _____

Patient Signature (or legal representative if a minor) Patient's Name (please print) Date

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Protected Health Information Disclosure

Effective April 14, 2003, a Federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your healthcare information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, this notice contains the information that HIPPA requires us to disclose regarding our privacy practices.

Existing California law also requires us, in addition to our attempt to obtain your written authorization discussed in the Notice, to first obtain your written consent prior to disclosing any of your healthcare information except in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

Any report of child or elder abuse may be reported to authorities as required by law. Any threats of violence against another person may be reported as per Tarasoff laws. Any strong concern for your safety may require disclosure of protected health information to facilitate prompt and appropriate evaluation or hospitalization by third parties if needed. Additionally, prescription of controlled substances such as narcotics may be reported to the California CURES database as required by law.

For some patients it might be necessary to make disclosures of healthcare information in connection with their treatment. This occurs most often when we refer a patient for consultation with a physician or other professional. If this or another type of referral were to be indicated for you that involved disclosure of your healthcare information, we would first discuss the purpose of the referral and the reason for disclosing your healthcare information. In addition, we would obtain your verbal and written permission before disclosing any information related to your treatment or your healthcare information.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today received a copy of our Notice.

_____ _____

Patient Signature (or legal representative if a minor) Patient's Name (please print)

Date: _____

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Consent for E-mail Communications

If you would like to allow communication by email, please read the following and below:

Dr. Yang offers patients, parents or guardians the opportunity to communicate by e-mail. Using e-mail to discuss patient information, however, is different than phone messaging. E-mail communication has a number of possible risks that patients, parents or guardians should consider before using e-mail. If the patient, parent or guardian is worried about any information being seen by other people, or if the question or problem is urgent, other form(s) of communication such as telephone communication should be used.

Risks of using e-mail:

Some of the possible risks of using email include, but are not limited to, the following:

- E-mail information can be sent on to other people, stored on a computer, or printed out on paper for storage.
- E-mail can be sent out and received by many recipients, some or all of whom may be sent the e-mail accidently.
- E-mail senders can easily misaddress an e-mail.
- E-mail information is easier to change than handwritten or signed documents.
- E-mail information may be kept on computers even after the sender or the recipient believes they deleted his or her copy.
- Employers and on-line services have a right to archive (store) and look at e-mails transmitted through their systems. Some, but not all, employers store e-mail messages indefinitely.
- E-mail can occasionally be intercepted, changed, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

CONDITIONS FOR THE USE OF E-MAIL

The Physicians or their approved designees will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, the Physicians or their approved designees cannot guarantee the security and confidentiality (privacy) of e-mail communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the federal Health

Insurance Portability and Accountability Act of 1996). Thus, the patient, parent or guardian must consent to the use of e-mail for patient information

We recommend the use of email providers that provide encryption like Gmail to reduce the risk of breach of privacy. We also recommend deleting emails after they have been read to reduce the risk of the emails being read or discovered at a later time. Check the address before sending emails. We may not be able to respond right away to email messages and if there is urgent need, please call.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the Physician/Practice has provided me regarding the Risks of using e-mail. I understand the Risks associated with the communication of e-mail between the Physician/Practice and me, and consent to the Conditions outlined. In addition, I agree to the above instructions, as well as any other instructions that the Physician/Practice may impose regarding e-mail communications.

_____ _____

Patient Signature (or legal representative if a minor) Patient's Name (please print)

Date: _____

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Fee Schedule and Billing

Treatment is fee-for-service at this time. In order to provide the best care possible and to be able to devote my time and energy to treatment rather than billing, I do not participate in any insurance networks. Instead of treatments being limited by the insurance companies, we can choose and apply the best treatment as mutually decided for however long or frequent as you like. This allows me to spend the time necessary to meet your needs as opposed to focusing on increased patient volume and billing. Also this allows for increased patient confidentiality since the insurance companies will only have access to what you provide them.

Many insurance companies have out-of-network benefits and I will happily provide a statement with appropriate coding to allow you to submit for reimbursement. The best way to find out what services and limits of coverage would be to contact your insurance company or employee benefit plan. Please be aware that insurances may not reimburse until the deductible is fully met but that requests should still be submitted in a timely manner.

I accept cash, check, credit card. Fees are fairly standard and based on the duration of the appointment.

$400 – 1 hour new patient visit or 1 hour medication/therapy follow up appointment. Usually involves 53+ minutes of discussion/treatment followed by 5 minutes of administrative needs such as setting next appointment and payment processing.

$200 – 30 minute medication or therapy follow up appointment. Usually involves 25+ minutes of discussion/treatment followed by 5 minutes of administrative needs such as setting next appointment and payment processing.

Other appointment types and durations are also available including phone or video chat appointments. Phone calls less than 5 minutes will not be charged however if it is determined that a quick phone call will be insufficient, an appointment will be offered or the extended call will be charged based on the duration.

Regular appointments are necessary for optimal care and safety. Frequency of visits will depend on severity of symptoms and risk factors and will be discussed in session. For therapy, once a week or every other week is recommended. For severe symptoms or increased risk of suicide once a week visits may be recommended. For moderate severity with ongoing medication adjustment, once a month visits may be considered. For low severity or when symptoms are stable and controlled, visits can be spread to once every 3 months. Follow up appointments more than 3 months out are not recommended. If it has been more than 6 months since the client was last seen, they may be discharged from the clinic as this would be below the standard of care for appointment frequency and it would be difficult to assess risk, control symptoms, or perform

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needed/recommended monitoring. Phone and email are for convenience of scheduling and for urgent concerns and are not meant to replace regular visits.

Refills will be provided for most medications at time of visit up to a maximum of three months depending on the indicated period for follow up and on whether the medication is being titrated or in maintenance phase. Controlled medications such as stimulants for ADD/ADHD or benzodiazepines for anxiety/insomnia may be provided on a month by month basis.

Missed appointments will be charged at 50% of the standard fee. Clients are ultimately responsible for remembering their appointment but a phone or email reminder will be sent out. Appointments can be cancelled without penalty up to 48 hours before their appointment. Due to past abuse, a valid credit card is required to be on file.

By signing below I agree to the above terms:

_____	_____
Patient Signature (or legal representative if a minor)	Patient's Name (please print)

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Credit Card Authorization

I am granting permission for Clarity Mental Health to bill my credit card for visits. I am also aware that my credit card will be charged for sessions in the event of non-attendance of an appointment not cancelled within 48 business hours of the appointment, or in the event of non-payment of a past due balance, or bill arising from professional services or obligation arising from care of the below mentioned patient.

Name of Patient: _____

Card Type: ☐ American Express ☐ Discover ☐ MasterCard ☐ Visa

Card Number: _____ Expiration Date: _____

CVV Number (3 or 4 digits): _____

Name on Credit Card: _____

Signature: _____ Date: _____

Home Address: _____

_____

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