Please keep this list of numbers with you at all times in case of an emergency.

1. If you are in crisis after office hours, please contact intake at the Bakersfield Behavioral Healthcare Hospital (661) 398-1800 or go as a walk-in to their Southwest location at 5201 White Ln., Bakersfield, CA 93309.
2. If you are agitated or become a threat to yourself and/or others, please contact 9-1-1.
3. If you have any questions or concerns regarding medication concerns and/or appointments after office hours or on a holiday, messages can be left with our answering service by dialing our office number.
4. If you need to talk to someone, please contact the Kern County crisis hotline at (800) 991-5272.
5. If you are requesting a medication refill, please contact your pharmacy.

*****Please be advised that all medications prescribed MUST be stored in a secure location as we will NOT be able to authorize a refill any medication before they are due under any circumstances. *****

Advanced Medical Psychiatric Services, Inc.

3409 Calloway Drive Unit 601, Bakersfield, CA 93312
(661) 589-1200 Fax: (661) 589-7200
rgamps@gmail.com

PATIENT INFORMATION FORM

Name: ____ Today's Date: _________
First Last

Address: ____
Street City State Zip

Phone: Home: ________________ Work: __________________ Cell: __________________

Date of Birth: ________________ Age: ____ Gender: ______ SSN: ______________________

Marital Status: ___________ Occupation: _______________ E-mail: ____________________

Emergency Contact: Name: ________________________________ Phone: ______________

How may we contact you to confirm appointments? (please circle all that apply) email, text, and/or voicemail

INSURANCE INFORMATION

PRIMARY (complete ONLY if you are not primary subscriber):

Policy Holder Name: ____
Last First M.I.

Relationship to Client (self, spouse, child, parent, other): ______________________________

Policy Holder Address:____
(If different from yours) Street City State Zip

Policy Holder Phone: _______________ Date of Birth: __________ SS#_____________________

Name of Insurance Company: ____

Member ID #:______________________________ Group #:______________________________

SECONDARY (if applicable):

Policy Holder Name: ____
Last First M.I.

Relationship to Client (self, spouse, child, parent, other): ______________________________

Policy Holder Address:____
(If different from yours) Street City State Zip

Policy Holder Phone: _______________ Date of Birth: __________ SS#_____________________

Name of Insurance Company: ____

Member ID #:______________________________ Group #:______________________________

TELEMEDICINE CONSENT FORM

Patient Name: ____________________________________ Date of Birth: ___________________

1. I understand that my health care provider wishes me to engage in a telemedicine consultation. This is due to the stand at home order by the Governor of the State of California due to novel COVID-19 pandemic. I am aware that telemedicine will cease once this order is lifted.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request to terminate the consultation at any time.

5. I understand that billing will occur from my practitioner, and I will provide any financial information as deemed necessary.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

____ _________________

Patient's/parent/guardian signature Date

AUTHORIZATION TO RELEASE AND/OR OBTAIN HEALTH INFORMATION

Patient Name:____ **Date of Birth:**_________________
First Last

__ I hereby authorize AMPS to release my medical information to _______________________________.
Name of Individual or Facility

Address of Individual or Facility:

____
Street City State Zip
Telephone of Individual or Facility:___________________________ Fax:_____________________________

__ I hereby authorize AMPS to obtain medical information from ________________________________.
Name of Individual or Facility
Address of Individual or Facility:

____
Street City State Zip
Telephone of Individual or Facility:___________________________ Fax:_____________________________

Records may be sent to:

Advanced Medical Psychiatric Services, Inc.
3409 Calloway Drive, Suite 601
Bakersfield, CA 93312
FAX: (661) 589-7200

Information to be Released/Obtained: Check all that apply:

	History and Physical		Progress Notes		Laboratory Reports
	Consultations		Other:		

Specific Authorizations: Check all that apply:

___ I authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
___ I authorize the release of information pertaining to mental health diagnosis or treatment.

My Rights

- I understand this authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. Under no circumstances, however, am I required to authorize the release of mental health records.

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- I am entitled to receive a copy of this Authorization.

____ **Date**:_____________________
Signature of Client or Client's Legal Representative

TREATMENT CONSENT FORM

Please read carefully, initial on each page, sign, and date on the last page.

MEDICATION

Medications may be recommended by your physician. If medications are indicated, we will discuss all the medication options that are available to treat your current condition. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal affects you may experience if you stop taking the medication abruptly. Such therapy requires strict adherence to dosage, and frequency, close follow-up, and sometimes regular blood tests. If a controlled substance is prescribed, note that **NO CONTROLLED SUBSTANCES WILL BE REFILLED BEFORE THEY ARE DUE TO CONTROL THE RISK OF MEDICATION MISUSE.**

_____ Initials

FREQUENCY AND DURATION OF VISITS

At your initial visit, we will decide together the structure of your treatment. If medications are prescribed, or changed, a follow-up visit will be scheduled per recommendation of your physician. This is necessary for medication adjustment and to evaluate medication side effects. Follow up visits will be determined by your physician as needed to monitor your psychiatric condition(s) and/or medication. We require each patient to follow up at least once every 3 months to ensure both the quality of care and safety and welfare of our patients. If you have **NOT** been seen in 6 months, your case will be closed.

_____ Initials

PAYMENTS AND FEES

Payment for services is due at the beginning of each visit. Payment is subject to the copayment and/or deductible as described by your insurance plan. Balance due for a private pay initial evaluation is **$200.00.** Balance due for follow up psychiatry and therapy visits is **$100.00.** Minimum charge for medical records or patient forms requests are **$60.00**. Minimum charge for all letters is **$20.00**. Any return payments will be charged a **$35.00** insufficient funds fee in addition to the fees processed by the financial institution.

_____ Initials

CANCELLATIONS AND NO-SHOWS

Any appointment cancellations and reschedules must be done so at least 24 hours (excluding weekends and holidays) prior to the appointment. Cancellations that occur with less than 24-hour notice or failure to show to an appointment will be charged **$25.00** for medication management, **$25.00** for therapy, and **$25.00** per hour for psychological testing.

_____ Initials

CONFIDENTIALITY

We follow all the HIPAA guidelines regarding the confidentiality of your records. Basic information about your treatment may be disclosed to your insurance company when necessary.

There are exceptions to this confidentiality, where disclosure is mandatory. These include the following:

-If there is a threat to the safety to yourself or others, we are required by law to take protective measures including reporting the threat to the potential victim, notifying police, seeking aid of family members or friends and seeking immediate hospitalization

- In situations where a dementing illness, epilepsy or other cognitive dysfunction prevent you from operating a motor vehicle in a safe manner, I will be required to report this to the DMV

- If a mental illness prevents you from providing for your own basic needs such as food, water, shelter, I will be required to disclose information to seek hospitalization.

_____ Initials

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form, you understand the scope of my services, session structure, fees, cancellation/no-show policies, payment policy, confidentiality, and you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client name (please print): ____ Date: __________________

Client's signature: ____

AUTHORIZATION FOR AUTOMATED BILL PAYMENT PROGRAM

Auto draft by Visa/Mastercard

Please return this form to: Advanced Medical Psychiatric Services, 3409 Calloway Drive, Suite 601, Bakersfield, CA 93312

Patient Name:

Address:

Primary Telephone Number:

Email:

☐ **I, ____________________________, authorize Advanced Medical Psychiatric Services to obtain payment by telephone for my scheduled appointment.** (By choosing this option, credit card information is not required but, please, still sign and date form.)

Visa/Mastercard Draft

Visa/Mastercard Number: ______________________________________ Security Code: _____________

Name on Card: ____________________________ Expiration Date: ___________________________
(Exactly as it appears on card)

Mailing address your card statements are received:

____

____
City State Zip Code

I, ____________________________, authorize Advanced Medical Psychiatric Services to obtain an automatic payment on my account in the amount of $_______.

____ on the day of my scheduled or $ 25 if I fail to cancel my appointment in less than 24 hours notice.

____ on the ____ day of every month until my balance is cleared.

____
Signature (REQUIRED) **Date**

MISSED APPOINTMENT AGREEMENT

<u>I UNDERSTAND AND AGREE TO THE FOLLOWING:</u>

1. I am aware that it is my responsibility to verbally notify Advanced Medical Psychiatric Services at (661)589-1200 ***24 hours (excluding weekends or holidays)*** prior to my scheduled appointment if I intend to cancel or reschedule that appointment.

2. I will be billed at the standard office rate of $25.00 for all medication management missed appointments, or $25.00 for missed therapy sessions, and $25.00 per hour for psychological testing missed appointments, and/or appointments cancelled with less than 24 hours (excluding weekends or holidays) of the scheduled appointment.

3. I agree to pay this amount if I miss an appointment or fail to cancel 24 hours (excluding weekends or holidays) prior to the scheduled appointment.

4. I am aware that a payment of $25.00 for missed medication management appointments or $25.00 for missed therapy appointments, and $25.00 per hour for psychological testing is required before my next appointment is scheduled.

____
Patient Name

____________________________ _____________________
Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________, have received a copy of AMPS Notice of Privacy Practices.
Print name here
Signature:____ Date:_________________________

NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW IT CAREFULLY.

My Pledge to Safeguard Your Protected Health Information

This notice is intended to inform you of the ways in which I may use and disclose medical information about you. It describes your rights and my obligations regarding the use and disclosure of your protected health information.

Protected Health Information (PHI) refers to any information in your medical record that could potentially identify you. It includes information about your past, present or future health or condition, the provision of health care to you, or payment for health care. Some examples of PHI include, but are not limited to: name, address, date of birth, age, phone number, diagnosis, medical record, and billing records.

I am required by state and federal law to maintain the security and privacy of your PHI, and to clearly outline my privacy practices, my legal obligations, and your rights in this Notice of Privacy Practices. This notice has been in effect since April 14, 2003, and I must abide by the terms described therein while it remains in effect.

How I May Use and Disclose Your Protected Health Information

In general, I am permitted to use/disclose your PHI for the purposes of treatment, payment for services, and for my normal health care operations. Most other uses/disclosures of your PHI will require your explicit permission via a signed Authorization. Below I outline the potential uses/disclosures of your PHI that do and do not require your written authorization, as described in the HIPAA Privacy Rule. Not every use or disclosure is listed, but they will fall within one of the following categories.

1) Uses and/or Disclosures of PHI for Treatment, Payment, and Health Care Operations That Do Not Require Authorization

Treatment: I may use/disclose your health information to a physician or other health care provider providing treatment to you or for the management of healthcare related services. This includes but not limited to consultations and referrals between one or more providers. I may disclose medical information about you to other physicians, nurses, technicians, medical students and other healthcare personnel that are involved in your care. For example, an insurance company may contact a provider on your behalf to facilitate your access to mental health treatment.

Appointment Scheduling/Reminders: The Privacy Rule allows me to contact you by phone/voicemail to schedule appointments and to leave appointment reminders unless you specifically request an alternate means of communication.

Payment: I may use/disclose your PHI in order to obtain payment for the services I provide. As an example, your health insurance company may need to determine your eligibility and the coverage you receive for mental health services. In such a case, I am permitted to disclose your PHI to your health insurer.

Health Care Operations: I may use/disclose your PHI for purposes of standard health care operations. For example, I may disclose your PHI to your medical health insurer for case management or care coordination purposes. In addition, your PHI may be used to comply with law and regulations, contractual obligations, patients' claims, grievances, or lawsuits.

2) Uses/Disclosures of PHI that Require Authorization

You may permit me via written authorization to use your health information or disclose it to anyone for any purpose. You may revoke that authorization in writing at any time. Any use/disclosure that took place while the authorization was in effect will not be affected by your revocation. Other than the permitted uses/disclosures described in this Notice, I cannot and will not use/disclose your PHI unless you give me written authorization.

3) Uses/disclosures of PHI that Do Not Require Your Authorization or Consent HIPAA Privacy Rule provides that I may use/disclose your PHI without your Authorization in several different circumstances outlined below.

As Required by Law: I may use/disclose your PHI when required to do so by federal or state law as listed below.

To Avert Serious Threat to Health or Safety: I may use/disclose your PHI when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone with the capacity to help stop or reduce the threat. For example, if you communicate an intent to harm an identifiable victim, I am required by law to communicate that information to the potential victim and to the police.

Abuse, Neglect, and Domestic Violence: I may disclose your PHI to appropriate authorities if I have a reasonable suspicion you are a possible victim of abuse, neglect, domestic violence or of other crimes.
Child Abuse: Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect has been the victim of child abuse or neglect, I must immediately report this to the police/sheriff's department, county probation department, child protective services, or county welfare department. If I have knowledge of or reasonable suspicion that a child has suffered psychological suffering as a result of verbal abuse, or that his/her emotional well-being is endangered in any other way, I may report this to the authorities listed above.

Adult and Domestic Abuse: If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, fiduciary abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these things, or if I have a reasonable suspicion this has occurred, I must report the known or suspected abuse immediately to the local ombudsman or local law enforcement. I do not have to report such an incident told to me by an elder or dependent adult if (a) I am not aware of any independent evidence that corroborates the statement that the abuse has occurred, (b) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and (c) in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

Military and Veterans: If you are or were a member of the armed forces, I may release medical information about you to military command authorities as authorized or required by law. We may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.

Public Health Disclosures: I may disclose PHI about you for public health purposes. These purposes include the following:

- Preventing or controlling the spread of disease or injury;
- Public health surveillance or investigations;
- Reporting adverse events with respect to food, medications, dietary supplements or problems with products;
- Notifying persons of recalls, repairs or replacements of products they may be using;
- Notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;
- Reporting to an employer finding concerning a work-related illness or injury or workplace-related medical surveillance;

Health Oversight Activities: I may use/disclose your PHI to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Judicial and Administrative Proceedings: I may disclose PHI to courts, attorneys, and court employees in the course of conservatorship and certain other judicial or administrative proceedings.

Lawsuits and Other Legal Actions: In connection with lawsuits or other legal proceedings, I may disclose your PHI in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement: I may use/disclose your PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death suspected to be the result of criminal conduct.

Coroners, Medical Examiners and Funeral Directors: In many circumstances, I may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death. I may also disclose PHI of clients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: As authorized or required by law, I may disclose your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities.
Protective Services for the President and Others: As authorized or required by law, I may disclose your PHI to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of law enforcement officials, I may disclose your PHI to the correctional institution as authorized or required by law.

4) Uses/Disclosures Requiring You to Have an Opportunity to Object:

I may disclose your PHI in the following circumstances if I inform you about the disclosure in advance and you do not object. I may use or disclose health information to notify or assist the notification of (including identifying or locating) a family member, your personal representative or another person responsible for our care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your PHI, I will provide you with an opportunity to object to such use/disclosure. However, in the event of your incapacity or emergency circumstances and you cannot be given an opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. I will disclose only health information that is directly relevant to the person's involvement in your healthcare. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Your medical record is my property. However, HIPAA Privacy Rule grants you the following individual rights regarding your PHI:

Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of your PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request I will locate and copy your health information for a reasonable and customary fee of $60.00 and postage if the copies are to be mailed. Under

certain circumstances, I may deny your request to inspect/copy your medical record. In such cases you may have the denial reviewed by another professional, and I will comply with the outcome of the review.

Right to Request an Amendment or Addendum: If you feel that your PHI in the medical record is incorrect or incomplete, you may request that I amend the information or add an addendum to the PHI.

The request must be made in writing and must clearly explain your reasons for the request. You have this right as long as the PHI is maintained in the medical record. I may deny your request to amend information if (a) the information was not created by me, (b) it is not part of the PHI kept by me, (c) it is not part of the information which you would be permitted to inspect and/or copy, and (d) it is accurate and complete in the record.

Right to an Accounting of Disclosures: You have the right to receive a list of certain disclosures I have made of your PHI.

Your request must be made in writing and state the time period (no longer than six previous years). You are entitled to one accounting within any 12-month period at no cost. Any additional requests in the same 12-month period you will be charged for the cost of compiling the accounting. You will be notified of the cost of the accounting before any costs are incurred so that you may choose to withdraw or modify your request.

Right to Request Restrictions: You have the right to request restrictions or limitation on certain uses and disclosures of PHI about you for treatment, payment or health care operations, as well as information disclosed to an individual in your care or the payment for your care, such as a family member or friend. I am not required to agree to a restriction you request. You do not have the right to limit the uses/disclosures that I am legally required or permitted to make according to the Privacy Rule. If I agree to the restriction/limitation, I will put the agreement in writing, and abide by it except in emergency situations.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. For example, if you do not want a family member to know you are receiving my services, you may request that I send your mailings to another address. You must make your request in writing, with specifics as to how and where you wish to be contacted. I will do my best to accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this Notice of Privacy Practices from me upon request.

Changes to My Privacy Practices and This Notice:

I reserve the right to change my privacy practices and this notice at any time provided the changes are permitted by applicable law. Prior to any changes, I will change this Notice, and make the new Notice available to you upon request. The revised Notice will be effective for PHI I already have about you as well as any information I receive in the future.

Contact Information:

Advanced Medical Psychiatric Services Inc.
3409 Calloway Dr., Suite 601, Bakersfield, CA 93312
Phone: (661) 589-1200 Fax: (661) 589-7200
E-mail: RGAMPS@gmail.com