1821 Wilshire Blvd., Suite 311
Santa Monica, CA 9040

Tel/fax: (310) 582-5252

1711 Via El Prado, Suite 204
Redondo Beach, CA 90277

REGISTRATION FORM

(Please Print)

Patient:____
Last Name First Name Middle Name

Is this your legal name: ☐ Yes ☐ No

If not, what is your legal name?__________________ Former Name:______________________

Responsible Party (if a minor):____

Home Phone:________________***Cell Phone:***________________***Email*:**________________

Street Address:____

City:______________________________ State:__________ Zip Code:____________

Sex: ☐ M ☐F Age:_____ DOB:____________ ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐Partnered for _____ years

Occupation:______________________ Employer:__________________________

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr.____________________

☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Other______________________

OTHER HEALTH CARE PROVIDERS:

Primary care provider: Dr.________________ Phone No.: ____________________

Therapist: ______________________ Phone No.: ____________________

Other:____

Preferred Pharmacy: __________________ Phone No.: ____________________

IN CASE OF EMERGENCY:

Name of friend/s or relative/s: ______________________________________

Relationship to patient: ☐ Spouse ☐ Friend ☐ Child ☐ Other

Address (if different):____

Home phone: ____________________ ***Cell/Work phone***: ____________________

I authorize Dr. Finklestein to contact the above person/s in case of emergency.

I hereby agree to pay for my treatment at the time of the service. I understand that I am financially responsible for all charges whether or not paid by the insurance or third party involvement. I hereby authorize Dr. Finklestein to release all information necessary to secure payment of benefits.

______________________________ ____________________

Signature of Patient/Parent/Legal Guardian **Date**

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CONSENT TO TREAT

Psychiatrists and Mental Health Professionals are governed by a code of ethics and by various laws and regulations. I would like to make you aware of a few points:

Patient's Rights:

Treatment is strictly voluntary and you may choose to discontinue treatment any time you wish.

Limits of Confidentiality:

Therapy sessions between a psychiatrist and patients are strictly confidential except under certain legally defined situations involving threats of self harm or harm to another, and cases of past or present child abuse, elder abuse or abuse of individuals. In case of danger to others, I am required by law to notify the police and to inform any intended victim(s). In case of self harm, I am legally bound to inform the nearest relative or significant other, or to enlist methods to prevent self-harm or suicide. In any instance of child abuse, elder or dependent abuse, I must notify the proper authorities.

I have read the above and give my permission to Dr. Finklestein to treat me. This consent remains valid until such time as I choose to discontinue treatment.

______________________________________ ______________________

Signature of Patient/Parent/Legal Guardian **Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Dr. Deborah Finklestein to release and receive health information to and from: Number of Individuals/Entities: __________________

Name______________________________________Phone #__________________________
Individuals or Entities Information May Be Released To and Received From

Name______________________________________Phone #__________________________
Individuals or Entities Information May Be Released To and Received From

Name______________________________________Phone #__________________________
Individuals or Entities Information May Be Released To and Received From

I understand that this information will be used for my treatment with Dr. Finklestein.

I understand that this release authorizes disclosure of information throughout the full duration of treatment with Dr. Finklestein regarding mental health, substance abuse, medical health, social history, and treatment. I understand that I may revoke this consent at any time.

______________________________ ________________
Signature of Patient/Parent/Legal Guardian Date

____
Printed Name

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OFFICE POLICIES AND PROCEDURES

Please take a moment to read over the following policies. Should you have any questions regarding any of these policies, please do not hesitate to discuss them with Dr. Finklestein. For a detailed outline of your insurance benefits or coverage, please contact your insurance company.

EVALUATION: The initial psychiatric evaluation will last approximately 60-90 minutes. During this evaluation, I will inquire into your current reason and motivation for seeking treatment, your medical, psychiatric, and substance abuse history, and questions regarding your social and occupational functioning. The evaluation is not a commitment to treatment; rather, it is an opportunity for me, and you, as the patient, to evaluate whether this is an appropriate treatment fit. In certain cases, I may require additional sessions to complete a thorough initial evaluation.

MEDICATION: Medication management appointments last approximately 25 minutes. If your optimal treatment would indicate medication, I will discuss the risks, benefits, and alternatives to medication options. I will discuss the appropriate dosage and frequency, as well as possible side effects that may arise. I invite you to ask any questions that you may have about medications, so that we are sure to address them adequately. During the initial phase of medication stabilization, more frequent appointments may be necessary. Once a stable and therapeutic medication regimen has been established, the frequency of appointments will decrease to monthly or bimonthly.

PSYCHOTHERAPY: Psychotherapy appointments last approximately 45-50 minutes, and usually occur weekly on a mutually agreed upon day and time. Psychotherapy appointments may also include medication management if that is part of the treatment plan.

CONFIDENTIALITY: It is my legal and ethical duty to keep all sessions confidential. Only under severe circumstances where I am concerned that you are an imminent danger to yourself, others, or unable to adequately provide for your own food, clothing, or shelter, I may be required to break confidentiality. In these situations, I will only reveal what information should be necessary to insure that you receive the best care possible. Other situations where I may need to break confidentiality in a limited fashion are: if you are being treated in an emergency room, if I suspect you are harming a minor or a vulnerable adult or if I am court ordered to provide information. Wherever possible, I would first discuss with you the urgency and necessity of the situation, with the goal of agreeing upon the need and extent of disclosure.

FEES AND REIMBURSEMENT: For fee information for initial psychiatric evaluation, psychotherapy and medication management appointments please call our office.

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My goal is that your treatment will occur during our scheduled time together. If circumstances dictate a significant amount of time outside of sessions, such as for extensive telephone calls, reviewing records, collecting collateral information, writing reports, or testifying, I will bill for the time by prorating your session fee. I do not contract with insurance companies; however, upon your request, I am happy to provide a superbill which can be submitted to your insurance company, and will allow you to be reimbursed part or all of my professional fees. Payment is collected at the beginning of each session, unless we agree otherwise. I accept cash, credit card (Visa/Mastercard/American Express) or check. There will be a $25 service charge for returned checks. I request that you advise me 48 business hours in advance of any cancellations. I do bill for no-shows, or cancellations that occur less than 48 business hours in advance. Please note that insurance companies will not reimburse for missed appointments.

COMMUNICATION: My voicemail number is: 310-582-5252. The voicemail is checked frequently between 9 am and 6 pm Monday through Friday. I do not routinely check my voicemail on weekends. I, or my assistant, Breanna, will return your call as promptly as possible, at least within one business day. If you have an emergent situation, please call 911 or go to your nearest emergency room. Please note that, although we do provide limited communication via email, it is not a secure or confidential form of communication, nor is it an appropriate way to reach us for urgent or emergent issues. If I will be unreachable or away for an extended period of time, I will leave the name and contact number of my covering physician.

Please sign and date below to indicate that you have read and agree to abide by the above office policies and procedures.

____ ________________________
Signature of Patient/Parent/Legal Guardian Date

____
Printed Name

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CREDIT CARD AUTHORIZATION FORM

To All Patients:

I appreciate and respect the trust you place in me to provide you with psychiatric care and services. Please understand that your benefit plan is an arrangement that involves you, your insurance carrier and your employer. Occasionally, there are charges such as a deductible, copay or co-insurance that are not covered by your insurance.

In order for my practice to run smoothly and continue to offer you high quality care, I respectfully request that you sign below to authorize Dr.Finklestein to keep your signature on file and charge your credit card for balances of charges that are not paid or covered by insurance including cancellations charges when applicable. ***I will automatically charge your credit card the fee for appointments that are not cancelled 48 hours in advance.***

Thank you for your cooperation.

Date:____

Name:____
please print clearly

Card type:(*please circle one)*
Visa   Mastercard   American Express

Credit Card Number:________________________________

Expiration Date:____________________________________

Security Code:(three digit code on back of card)   ________

Billing Zip Code:____________________________________

Signature:____
(patient)

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Private Practices Acknowledgement Form

I hereby acknowledge that I have received the Notice of Private Practices (Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA) and I have been provided an opportunity to review it.

Office Policies and Procedures Acknowledgement Form

I have received the Office Policies and Procedures Acknowledgement form and I have been provided an opportunity to review it.

______________________________ ______________________________
Signature of Patient/Parent/Legal Guardian Date

____
Printed Name

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY. NOTICE OF PRIVACY POLICY

The following is the privacy policy ("Privacy Policy") of Deborah Finklestein M.D. as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

***Examples of treatment activities include*:** (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

***Examples of payment activities include*:** (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage,

adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work- related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

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Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or
(e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right to Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

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Right to Inspect and Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right to Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health

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information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to 235 Avenida del Norte, Redondo Beach, 90277.**Right to Receive An Accounting Of Disclosures Of Your Personal Health Information**

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization,
(c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to 235 Avenida del Norte, Redondo Beach, 90277.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail 235 Avenida del Norte, Redondo Beach, 90277. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

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On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to 235 Avenida del Norte, Redondo Beach, 90277.
For any other requests or for further information regarding the privacy of your personal health information, please contact us at 310-582-5252.