

MEMORIAL COUNSELING ASSOCIATES

Welcome to our office.

The following policies are intended to facilitate your care and minimize procedural problems.

OFFICE HOURS: The office staff is available from 9:00 a.m. to 5:00 p.m., Monday-Friday. In the event of an after hours emergency or a problem on a weekend or holiday, an answering service is available 24 hours a day to address your concerns and reach the appropriate provider.

APPOINTMENTS: Patients are seen by appointment only. We require **24 hours notice** in order to cancel or reschedule appointments or you will be charged for the scheduled appointment. **PLEASE BE AWARE PATIENTS WILL BE CHARGED A MAXIMUM OF \$100 PER MISSED APPOINTMENT.** Initial _____

PATIENT INFORMATION: We ask that a patient information form be filled out before your first visit with the doctor. Periodically, we may request information from you to update our files. **Your e-mail address will remain confidential. Your e-mail address will only be used for communication and information from Memorial Counseling Associates.**

INSURANCE: In the state of California, a patient is financially responsible for all medical services rendered. Obtaining authorization and eligibility from your insurance company is a courtesy provided by our office. Please assist us by providing us with all necessary information to expedite your claims. **Co-pays and deductibles are due at time of service.** Initial _____

PATIENT CONFIDENTIALTY: There are three topics which a therapist cannot keep confidential. We must report all occasions of child abuse, elder abuse, or sexual molestation to the proper authorities. In addition, we must act to protect you from yourself if you are suicidal and we must act to protect a potential victim if you are homicidal. Everything else is governed by the laws of confidentiality and no information may be given out without your written consent.

If you have any questions or concerns, please feel free to call the office during normal business hours for assistance.

I have read the above policies, understand them completely, and agree to the conditions set forth.

Patient Signature

Date

**Acknowledgment of Receipt
of Notice of Privacy Practices under HIPAA**

**Memorial Counseling Associates
4525 Atherton Street
Long Beach, CA 90804**

Patient Name: _____ **Birthdate:** _____

Doctor's Name: _____

**I acknowledge that I have been informed of the Notice of Privacy Practices for HIPAA of
Memorial Counseling Associates, effective April 14, 2003. Initials:** _____

Signature: _____ **Date:** _____

Signature if signed by authorized representative: _____

Relationship/Authority (if signed by authorized representative): _____

*Policy and Procedure manual provided upon request.



Memorial Counseling Associates
Memorial Psychiatric Health Services

CONSENT FOR SERVICES

The undersigned client or responsible adult* consents to and authorizes mental health services by

Practitioner

These services may include psychological testing, psychotherapy/counseling, rehabilitation services, medications, case management, laboratory tests, diagnostic procedures, and other appropriate services.

The undersigned understands:

He/she has the right to be informed of and participate in the selection of evaluation, treatment, rehabilitative, and case management services which will be provided.

All of the above services are voluntary and he/she has the right to request a change in service provider or withdraw this consent at any time.

Signature of Client

Date

Signature of Responsible Adult

Relationship to Client

Date

Witness attests: () I have completed or have caused to be completed the Consent of Minor form for any client under the age of 18 signing without parental/guardian consent.

Signature of Witness

Date

Signatory () was given or () refused a copy of this consent on _____ by _____.

* Responsible Adult = Guardian, Conservator, or Parent of Minor

MEMORIAL COUNSELING ASSOCIATES, INC.
Patient Information Sheet

Date: _____ Clinician: _____

Patient Name: _____

Address: _____

City: _____ Zip Code: _____

*E-Mail Address: _____

Home Tel #: _____ Work Tel #: _____

Date of Birth: _____ Social Security #: _____

Marital Status: _____ Gender: ___ M ___ F Age: _____

Reason for Appointment: _____

Referred by: _____

Alcohol Use: (circle) Yes No (If yes, what?) _____

Drug Use: (circle) Yes No (If yes, what?) _____

Suicidal Thoughts: _____ Prior Suicide Attempts: _____

Emergency Contact: _____ Phone #: _____

Patient is Conserved: (circle) Yes No If yes: Public Guardian ___ Private Conservator ___

Name of Conservator: _____ Tel #: _____

INSURANCE INFORMATION

Insurance Company: _____ Plan Type: _____

Insured Employer: _____ Tel #: _____

Insured Person's Name: _____ Insured DOB: _____

Insured Soc. Sec. #: _____ Relationship: _____

Secondary Insurance Co: _____ Plan Type: _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to: _____ (the doctor) of the insurance benefits otherwise assigned to me. I understand that I am financially responsible for the charges not covered by this authorization. If it becomes necessary for the account to be referred to an attorney for collection or suit, the undersigned shall pay for all attorney's fees and collection expenses.

Signed: _____ Date: _____

*Your e-mail address will remain confidential. Your e-mail address will only be used for communication and information from Memorial Counseling Associates.

MEMORIAL COUNSELING ASSOCIATES

CONSENT TO PSYCHOPHARMACOLOGICAL MEDICATION

Date: _____

Patient Name: _____

Date of Birth: _____

I have met with my physician and have discussed the use of medication for the treatment of my emotional/mental condition. The following information was discussed with me:

- a) The nature of my mental condition.
- b) The reason for prescribing and taking such medications, including the likelihood of improving or not improving without such medication.
- c) The reasonable alternative treatments, if any.
- d) The type, range of frequency and amount, and the period of time during which such medications are likely to be prescribed for me.
- e) The common side effects known to occur and any particular side effects likely to occur in my case, including metabolic changes, diabetes and weight gain.

MEDICATION	DOSAGE RANGE/DAY

I have been advised of, and understand, all of the above information and consent to receiving these medications as prescribed for me.

DOCTOR: _____

SIGNATURE OF PATIENT

DATE: _____

SIGNATURE OF PARENT/LEGAL GUARDIAN

Note: If applicable, guardian needs to show proof of guardianship.



Memorial Counseling Associates
Memorial Psychiatric Health Services

Appointment Reminder Policy

It is our company policy to contact every patient either the day before or the morning of your appointment. Should your appointment fall on a Monday, we will contact you the Friday prior to your appointment. If you do not answer, we will then leave a message on your machine if you have one. Please provide the following information to help us better serve you.

_____ **I wish to be contacted** before an appointment. Please provide the following information help us better serve you:

Name _____

Contact Phone Number _____

_____ **I do not wish to be contacted** before an appointment. (Please do not fill in a contact number if you choose this option.)

Signature