Oak Health Center, A Medical Corp.
23141 Moulton Pkwy. Suite 213
Laguna Hills, CA 92653
Tel: 949-258-3741
Fax: 949-258-3742
www.oak.care

Oak Health Center

GENERAL PRIVATE PRACTICE CONTRACTUAL AGREEMENT

This document contains important information regarding professional services and business policies of Oak Health Center, A Medical Corporation ("Oak Health Center"). Please read it carefully. This signed document represents the General Private Practice Contractual Agreement ("Agreement") between the parties as indicated below.

I, _____ ("Patient/Client"), agree to be a patient/client of Oak Health Center.

1. FULL DISCLOSURE

I am responsible to fully disclose to Oak Health Center any and all legal actions that I am involved in that are ongoing or pending. I agree that my provider or providers at Oak Health Center will not act as expert witnesses in any legal matter that I am involved in, unless agreed to in writing between the patient/client and the provider. Any failure on my part to disclose any and all legal actions that I am involved in, and/or to obtain my provider's written agreement with respect to being an expert witness in any legal action may result in termination of Oak Health Center's services to me.

2. PAYMENT FOR SERVICES

I understand that I am responsible for payment of all rendered professional services due and payable at the time of each visit, unless such services are covered by an insurance carrier that Oak Health Center is contracted with. Oak Health Center is not responsible in any way with respect to the type of coverage provided by a particular health plan, and I understand that Oak Health Center will not guarantee any reimbursement I receive from an insurance carrier.

I agree to pay Oak Health Center in cash, check, or credit card at the time of each visit. In the event that my insurance is not billable, out-of-network rates will apply for my respective provider(s).

The following services will be billed at the rate of $50 per ten-minutes ($300 per hour):

- Review of Medical Records
- Literature reviews/research;
- Interaction with pharmacies, medical institutions, physicians, or administrative staff/personnel exceeding 5 minutes in length;
- Written correspondence; including disability requests, letters to employers, courts, or insurance carriers exceeding 5 minutes in length;
- Telephone appointments/consultations, and/or patient/client related phone calls exceeding 5 minutes in length;
- Family interaction or feedback exceeding 5 minutes in length;

Checks returned for non-sufficient funds shall be charged a twenty-dollar ($20.00) processing fee.

3. CONFIDENTIALITY OF E-MAIL, CELLULAR TELEPHONE, TEXT MESSAGES, AND FAX COMMUNICATIONS

E-mail and cell phone communications (including text messages) can be accessible by unauthorized people and the privacy and confidentiality of such communications can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. A fax can easily be sent erroneously to the wrong address. The Patient/Client must, in writing, notify Oak Health Center at the beginning of treatment if the Patient/Client decides to avoid or limit in any way the usage of any or all of the above mentioned devices.

4. TELEPHONE AND EMERGENCY PROCEDURES

If the Patient/Client needs to contact their provider between visits, the Patient/Client should use the telephone number provided in this Agreement. The Patient/Client's call will be returned as soon as possible. If it is difficult to reach the Patient/Client, the Patient/Client should inform their provider when he/she is available. If the Patient/Client is unable to reach their provider, and the Patient/Client cannot wait for their provider's return call, the Patient/Client should contact a family physician or the nearest hospital emergency room, and ask for the clinician/psychiatrist on call to attend to the Patient/Client's medical situation. If the Patient/Client's Oak Health Center provider is unavailable for an extended period of time, the provider will provide the Patient/Client with the contact information of a colleague, if necessary.

If there is an emergency during a session and Oak Health Center becomes concerned about the Patient/Client's personal safety, the Patient/Client's well-being, and/or potential injury to others, Oak Health Center may contact the person indicated in the Patient/Client Information Record.

5. THE PROCESS OF PSYCHOLOGICAL EVALUATION

Participation in therapy/treatment can result in a number of benefits to the Patient/Client, including improved interpersonal relationships and resolution of the specific concerns that led the Patient/Client to seek therapy. Working toward these benefits requires effort on the part of the Patient/Client. The process requires the Patient/Client's active involvement, honesty and openness in order to change the Patient/Client's thoughts, feelings and/or behavior. The treating provider at Oak Health Center will ask for the Patient/Client's feedback and views regarding progress, and will expect the Patient/Client to respond openly and honestly. During the evaluation(s), remembering or talking about unpleasant events, feelings, or thoughts can result in the Patient/Client experiencing considerable discomfort or strong feelings such as anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. The provider may challenge some of the Patient/Client's assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that may cause the Patient/Client to be upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues

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that brought the Patient/Client to seek treatment in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Changes will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that all treatments will yield positive or intended results.

6. DISCUSSION OF TREATMENT PLAN

Within a reasonable time after the initiation of treatment, the treating provider will discuss with the Patient/Client, his/her working understanding of the problem, treatment plan, and his/her view of the possible outcomes of treatment. If the Patient/Client has any unanswered questions about any of the procedures, the Patient/Client may discuss them with their provider.

7. TELEBEHAVIORAL HEALTH SESSIONS

Electronic Presence: In brief, the Patient/Client understands that the provider will not be physically in his/her presence during a tele-session. Instead, both parties will see and hear each other electronically, or that other information such as information the Patient/Client enters into an "app" will be transmitted electronically to and from him/her and the provider.

Software Security Protocols: Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations: This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service. Regardless of the sophistication of today's technology, some information the provider would ordinarily get in in-person consultation may not be available in teleconsultation. The Patient/Client understands that such missing information could in some situations make it more difficult for the provider to understand his/her problems and to help him/her get better. The provider will be unable to physically touch the Patient/Client or to render any emergency assistance if he/she experiences a crisis.

Risks: The Patient/Client understands that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons. In rare instances, security protocols could fail, causing a breach of privacy of personal health information.

Technology Requirements: The Patient/Client will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

Local Practitioners: If a need for direct, in-person services arises, it is the Patient/Client's responsibility to contact practitioners in his/her area such as other providers at Oak Health Center, or to contact the provider's extension for an in-person appointment, or the primary care physician if the provider is unavailable. The Patient/Client understands that an opening may not be immediately available in either office.

Risks of Technology: These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan: The Provider and the Patient/Client will regularly reassess the appropriateness of continuing to deliver services to the Patient/Client through the use of the technologies agreed upon today, and modify the plan as needed.

Disruption of Service: Should service be disrupted, the Patient/Client should make an attempt to stay in the virtual waiting room for reconnection. If that is not possible, the Patient/Client should call Oak Health Center for instructions. It may be necessary to communicate by other means. In such situations, the provider will call the phone number listed in the patient/client's file. It will be Patient/Client's responsibility to keep the phone number on file current and accurate.

Provider Communication: The provider may utilize alternative means of communication in the following circumstances, if the provider is unable to connect via the standard video conferencing software.

Patient/Client Communication: It is the Patient/Client's responsibility to maintain privacy on the Patient/Client end of communication. Insurance companies, those authorized by the Patient/Client, and those permitted by law may also have access to records or communications.

Emergency Protocol: The Patient/Client acknowledges, however, that if he/she is facing or if he/she thinks he/she may be facing an emergency situation that could result in harm to the Patient/Client or to another person; the Patient/Client is not to seek a telebehavioral consultation. Instead, the Patient/Client agrees to seek care immediately through his/her own local health care practitioner or at the nearest hospital emergency department or by calling 911. The Patient/Client is aware that the provider may contact the proper authorities and/or his/her designated, local contact person in case of an emergency.

Release of Liability: The Patient/Client unconditionally release and discharge Oak Health Center, its affiliates, agents, and employees; and the provider and his or her designees from any liability in connection with the Patient/Client's participation in the remote consultation(s).

8. TERMINATION

As set forth above, after one to two (1-2) meetings, the treating provider and the Patient/Client will assess if treatment will benefit the Patient/Client. Oak Health Center does not accept patient/clients who, in the provider's opinion, the provider is unable to help. In such cases, Oak Health Center may provide

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appropriate referrals. In addition, if at any point in the treatment procedure, the provider concludes that the treatment procedure is not helping the Patient/Client, the provider will discuss the matter with the Patient/Client and, if appropriate, terminate treatment of the Patient/Client. In such a case, the provider will also make appropriate referrals that may be of assistance to the Patient/Client. Upon the Patient/Client's written request and authorization, the provider will discuss the Patient/Client's decision with another professional in order to help with the transition.

9. ADDITIONAL SERVICES FOR ADDITIONAL FEES

Oak Health Center may, from time to time, offer additional services which are not included in this Agreement. Patient/Client is not obligated to pay for additional services, however, if Patient/Client agrees to any additional services not included in this Agreement, Patient/Client will be obligated to pay such additional fee.

10. SERVICES NOT PROVIDED BY OAK HEALTH CENTER

Oak Health Center does not provide hospitalization, specialty health care, x-rays, laboratory work, and emergency room visits for the Patient/Client. Patient/Client should maintain health insurance coverage for these medical services.

11. NON ASSIGNABILITY OF AGREEMENT

This Agreement is between Oak Health Center and Patient/Client only. Patient/Client may not assign to another person or entity the services which are agreed upon in this Agreement.

ACKNOWLEDGMENT BY CLIENT: By signing below, the Patient/Client acknowledges that he/she has read this agreement for mental health services, and that he/she understands and agrees with all the terms and conditions set forth in this Agreement. (Please complete below and return this Agreement with the initial visit.)

_____	_____	_____
Printed Name of Patient/Client, or Legal Guardian of Patient/Client	Signature of Patient/Client, or Legal Guardian of Patient/Client	Date

If signed by other than Patient/Client, indicate relationship: _____

If Patient/Client is unable to sign, then verbal consent is given. Specify Reason: _____

_____	_____	_____
Printed Name of Witness	Signature of Witness	Date

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ARBITRATION AGREEMENT

ARTICLE 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this Agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this Agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by Oak Health Center, including any spouse or heirs of the Patient/Client and any children, whether born or unborn at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient/client" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against Oak Health Center and Oak Health Center's partners, associates, association, corporation, entity or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by Oak Health Center to collect any fee from the Patient/Client shall not waive the right to compel arbitration of any malpractice claim.

The parties also agree that if this Agreement is executed on behalf of some other person or patient/client, then, in addition to the Patient/Client, such person(s)/patient(s)/client(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person/patient/client.

ARTICLE 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties to this Agreement. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including attorney's fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Each party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties hereby consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties hereby agree that provisions of California law applicable to health care providers shall apply to disputes within this Arbitration Agreement, including, but not limited to, California Code of Civil Procedure, Sections 340.5 and 667.7 and California Civil Code, Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or a motion for summary adjudication in accordance with California Code of Civil Procedure. Discovery shall be conducted pursuant to California Code of Civil Procedure, Section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

ARTICLE 4: **Validity and Enforceability:** The parties hereby agree that Patient/Client and Oak Health Center shall be bound by this Arbitration Agreement and that this Agreement will be valid and enforceable for any and all treatment provided by Oak Health Center, regardless of the length of time since the Patient/Client's last visit to Oak Health Center, and regardless of the fact that the Patient/Client-physician relationship between the Patient/Client and Oak Health Center may be interrupted for any reason and then recommenced.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

ARTICLE 5: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one (1) proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

ARTICLE 6: **Revocation:** This Arbitration Agreement may be revoked by written notice delivered to Oak Health Center within thirty (30) days from the date of the Patient/Client's signature below. It is the intent of this Arbitration Agreement to apply to all medical services rendered any time for any particular medical condition.

ARTICLE 7: **Retroactive Effect:** If Patient/Client intends that this Arbitration Agreement cover services rendered before the date that this Agreement is executed (including, but not limited to, emergency treatment), Patient/Client should initial below:

Effective as of the date of first medical services

_____
Patient/Client's or Patient/Client Representative's Initials

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NOTICE: BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE AND/OR ANY ISSUE RELATED TO THIS AGREEMENT BE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS AGREEMENT.

Printed Name of Patient/Client, or Legal Guardian of Patient/Client	Signature of Patient/Client, or Legal Guardian of Patient/Client	Date

If signed by other than Patient/Client, indicate relationship: _____

If Patient/Client is unable to sign, then verbal consent is given. Specify Reason: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient/Client-Provider Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement.

Printed Name of Witness	Signature of Witness	Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

OAK HEALTH CENTER, A MEDICAL CORPORATION IS REQUIRED BY LAW TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION ("PHI").

The PHI constitutes information created or noted by Oak Health Center that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. We are required to provide you this notice about our privacy procedures. This notice must explain when, why, and how we would use and/or disclose your PHI. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice. PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. However, we are always legally required to follow the privacy practices described in this notice.

Please note that we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, this notice will be updated and a copy will be available to you upon request.

HOW WE WILL USE AND DISCLOSE YOUR PHI

We will use and disclose your PHI for different reasons. Some of the uses of disclosure will require your prior written consent, others, however will not. Please find below the various categories, and examples, for our use and disclosures.

USE AND DISCLOSURES RELATED TO TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS DO NOT REQUIRE YOUR PRIOR WRITTEN CONSENT. WE MAY USE AND DISCLOSE YOUR PHI WITHOUT YOUR CONSENT FOR THE FOLLOWING REASONS.

For treatment- We may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychologist or therapist is treating you, we may disclose your PHI in order to coordinate your care.

For Health Care Operations- We may disclose your PHI to facilitate the efficient and correct operation of our practice. Examples: Quality control where we might use your PHI in the evaluations of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. We may also provide your PHI to our attorneys, accountants, consultants, and others to make sure that we are in compliance with applicable laws.

To obtain payment for treatment- We may use and disclose your PHI to bill and collect payment for the treatment and services we provide you. Example: We might send your PHI to your insurance company or health plan provider in order to get payment for the health care services that we have provided to you. We could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for our office.

Other disclosures- Examples: Your consent is not required if you need emergency treatment provided that we attempt to get your consent after treatment is rendered. In the event that we try to get your consent but you are unable to communicate with us (for example, if you are unconscious or in severe pain), and we think that you would consent to such treatment if you could, we may disclosure your PHI.

Certain other uses and disclosures do not require your consent. We may use and/or disclose you PHI without your consent or authorization for the following reasons:

The following list is a compilation of federal and California laws.

- When disclosure is required by federal, state, or local law, judicial board, administrative proceedings or law enforcement. Example: We may make a disclosure to the appropriate officials when a law requires us to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
- If disclosure is completed by a party to a proceeding before a court or an administrative agency pursuant to its lawful authority.
- If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
- If disclosure is compelled by the Client or the Client's representative pursuant to California Health and Safety Codes or to corresponding federal statutes or regulations, such as the Privacy Rule that requires this Notice.
- To avoid harm. We may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person of the public.
- If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if we determine that disclosure is necessary to prevent the threatened danger.

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- If disclosure is mandated by the California Child Abuse and Neglect Reporting Law. For example: If we have a reasonable suspicion of child abuse or neglect.
- If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting Law. For example: If we have a reasonable suspicion of elder abuse or dependent adult abuse.
- If disclosure is compelled or permitted by the fact that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.
- For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.
- For health oversight activities. Example: We may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
- For specific government functions. Examples: We may disclose PHI of military personnel and veterans under certain circumstances. Also, we may disclose PHI in the interest of national security, such as protecting the President of the United States or assisting with intelligence operations.
- For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.
- For workers' compensation purposes. We may provide PHI in order to comply with Workers' Compensation laws.
- Appointment reminders and health related benefits or services. Examples: We may use PHI to provide appointment reminders. We may use PHI to give you information about alternative treatment options, or other health care services or benefits we offer.
- If an arbitrator or arbitration panel compels disclosure. If disclosure is required pursuant to subpoena duces tecum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
- We are permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.
- If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess our compliance with HIPAA regulations.
- If disclosure is otherwise specifically required by law.

Certain uses and disclosures require you to have the opportunity to object. Disclosure to family, friends or others. We may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

Other uses and disclosures require your prior written authorization. In any other situation not described above, we will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that we haven't taken any action subsequent to the original authorization) of your PHI by us.

YOUR RIGHTS REGARDING YOUR PHI

The right to inspect and obtain copies of your PHI. In general, you have the right to see your PHI that is in our possession or to get copies of it. However, you must request it in writing. If we do not have your PHI, but we know who does, we will advise you how you can obtain it. You will receive a response from us within thirty (30) days of our receipt of your written request. Under certain circumstances, we may feel we must deny your request. If so, we will respond in writing the reasons for denial. We will also explain your right to have our denial reviewed.

If you ask for copies of your PHI, we will charge you not more than $.25 per page. We may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

The right to request limits on uses and disclosures of your PHI. You have the right to ask that we limit how we use and disclose your PHI. While we will consider your request, we are not legally bound to agree. If we do agree to your request, we will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

The right to choose how we send your PHI to you. It is your right to ask that your PHI be sent to you at an alternate address (e.g., sending information to your work address rather than to your home address) or by an alternate method (e.g., by e-mail or by regular mail). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested without undue inconvenience.

The right to get a list of the disclosures we have made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses of disclosures to which you have already consented, i.e. those for treatment, payment, or health care operations, sent directly to you, or to your family. The list will not include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before November 17, 2006. After November 17, 2006, disclosure records will be held for six (6) years.

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We will respond to your request for an accounting of disclosures within sixty (60) days of receiving your request. The list we give you will include disclosures made in the previous six (6) years (the first six year period being 2006-2012) unless you indicate a shorter period. The list will include the date of disclosure, to whom PHI was disclosed (including the address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no cost, unless you make more than one (1) request in the same year, in which case we will charge a reasonable amount for each additional request.

The right to amend or revise your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reason for the request must be in writing. You will receive a response within sixty (60) days of our receipt of your request. We may deny your request, in writing, if we find that, (a) the PHI is correct and complete, (b) forbidden to be disclosed, (c) not part of our records or (d) written by someone who is not a part of our practice. Our denial must be in writing and must state the reason for denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.

The right to get this notice by E-mail. You have the right to get this notice by E-mail. You have the right to request a copy as well.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact us at our address above.

If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint with us at the address listed above. You may also send a written complaint to the Secretary of the Department of Health and Human Services, 200 Independence Avenue S.W. Washington, D.C. 20202.

THIS NOTICE IS EFFECTIVE AS OF MARCH 1, 2016.

I HAVE READ, AND FULLY UNDERSTAND, THE ABOVE INFORMATION REGARDING MY PRIVACY RIGHTS.

_____	_____	_____
Printed Name of Patient/Client, or Legal Guardian of Patient/Client	**Signature of Patient/Client, or Legal Guardian of Patient/Client**	**Date**

If signed by other than Patient/Client, indicate relationship: _____

If Patient/Client is unable to sign, then verbal consent is given. Specify Reason: _____

_____	_____	_____
Printed Name of Witness	**Signature of Witness**	**Date**

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APPOINTMENT CANCELLATION POLICY

We strive to provide excellent mental health care to you, your family and all of our patients/clients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for a patient/client.

No-Shows and late cancellations inconvenience those individuals who need access to care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented an Appointment Cancellation Policy and it is effective immediately.

Our policy is as follows:

1. We request you give our office a 24-hour notice in the event you need to reschedule your appointment. Our phone number is (949) 258-3741.
2. If you miss an appointment and do not contact us with at least a 24 hour prior notice, we will consider this a missed appointment and a $100.00 no-show fee will be assessed to you. This applies to late cancellations and no-shows.
3. Our office provides courtesy text reminders for appointments. It is ultimately the Patient/Client's responsibility to remember their scheduled appointments.

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment.

We thank you for trusting Oak Health Center with your mental health care.

ACKNOWLEDGMENT BY CLIENT: By signing below, the Patient/Client acknowledges that he/she has read this agreement for mental health services, and that he/she understands and agrees with all the terms and conditions set forth in this Agreement. (Please complete below and return this Agreement with the initial visit.)

_____	_____	_____
Printed Name of Patient/Client, or Legal Guardian of Patient/Client	**Signature of Patient/Client, or Legal Guardian of Patient/Client**	**Date**

If signed by other than Patient/Client, indicate relationship: _____

If Patient/Client is unable to sign, then verbal consent is given. Specify Reason: _____

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AUTHORIZATION FOR CREDIT CARD BILLING

This form is for your convenience to take care of any copayments, co-insurances, deductibles, and/or balances. Your card will be processed at the beginning of each appointment. Should you have a Health Savings Account or Flex Spending Account that you would like for us to process first, please indicate below.

Receipt via (choose only 1): ☐ PRINTED ☐ EMAILED to: _____ ☐ NO RECEIPT

OHC Patient/Client's Name: _____

Primary Card: Is this an HSA/FSA card? ☐ Yes ☐ No

Card Holder's Full Name (as it appears on the card)			
Card Number			
Expiration (MM / YY)		Billing Zip Code	

Secondary Card: Is this an HSA/FSA card? ☐ Yes ☐ No
(to charge if Primary Card unavailable)

Card Holder's Full Name (as it appears on the card)			
Card Number			
Expiration (MM / YY)		Billing Zip Code	

Card Holder's Signature Date

_____

**Please be advised that the Card Holder's Signature authorizes Oak Health Center to charge the Card Holder's credit card account. Should your card not process successfully, it is the Card Holder's responsibility to make prompt payment towards any outstanding balances prior to the next appointment.*

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AUTHORIZATION FOR CREDIT CARD BILLING

(continued)

For security purposes, we ask that you record your CVV code on this second page of the Authorization for Credit Card Billing form.

OHC Patient/Client's Name: _____ Date: _____

Primary Card:

CVV Code	

Secondary Card:

CVV Code	

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PATIENT/CLIENT INTAKE QUESTIONNAIRE

Welcome to Oak Health Center! In order to serve you properly, we will need the following information. Please complete the following information about the patient/client to the best of your ability.

Today's Date		How was the patient/client referred here?	
Purpose of Evaluation			
Name of person completing this form *(if not the patient/client)*			

IDENTIFYING INFORMATION

Patient/Client Name (Last, First)					
DOB		Age		Ethnicity of Patient/Client *(optional)*	
Gender *(optional)*	☐ M ☐ F ☐ Other _____				
Name of Legal Guardians* (for child patient/client)					

**If biological parent is not the current legal guardian, please attach appropriate documents.*

CONTACT INFORMATION

Street Address					
City		State		Zip	
Primary Phone		Other:			
Phone Number of Caregiver *(if not same as above)*					
Email Address *(or of Caregiver if Child Patient/Client)*					

EMERGENCY CONTACT

Name		Relation to Patient/Client	
Phone Number		Will accept text messages?	☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance Company		ID Number	
Name of Primary Subscriber *(if not patient/client)*			
Secondary Insurance Company		ID Number	

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PRESENTING PROBLEM

What are the main problems the patient/client is seeking help for?

PAST PSYCHIATRIC HISTORY

Has the patient/client ever seen a psychiatrist (medical doctor) or therapist (counselor)?	☐ Yes ☐ No			
If yes, for what condition(s)?				
Name of previous psychiatrist(s)				
Name of previous therapist(s)				
Has the patient/client ever attempted suicide?	☐ Yes ☐ No			
Describe previous suicidal attempts or behaviors				
Previous Given Diagnoses (if known)	1.			
	2.			
	3.			
Has the patient/client ever taken prescribed psychiatric medications?	☐ Yes, please list below ☐ No			

	Name of Medication *(Past & Present)*	Highest Doses & Frequency per Day	When taken? *(Month/Year to Month/Year)*	Reason for Discontinuing
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Has the patient/client ever been in the hospital or rehab center for a psychiatric condition?	☐ Yes ☐ No

	Name of Hospital(s)/Inpatient Rehab(s)	Dates
1.		
2.		

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Family Psychiatric History

Has anyone in the patient/client's biologically related family (mother, father, siblings, relatives) had the following mental health conditions?

Drug or alcohol abuse	☐ Yes	☐ No
Anxiety disorder	☐ Yes	☐ No
Major depression	☐ Yes	☐ No
Suicide or suicide attempts	☐ Yes	☐ No
Psychiatric hospitalizations	☐ Yes	☐ No
Psychiatric medications	☐ Yes	☐ No
Therapy/counseling	☐ Yes	☐ No
Attentional or learning problems	☐ Yes	☐ No
Manic depression/bipolar disorder	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Criminal history or time in prison	☐ Yes	☐ No

	Family Member	Psychiatric Diagnosis/Problem	Treatment Received
1.			
2.			
3.			
4.			

Medical History

Primary Care Provider's Name		Date of Last Physical Exam	
Address & Phone Number			
Other Medical Specialist & Phone Number			
Does the patient/client have any allergies to medications?	☐ No ☐ Yes, allergic to _____		
Immunizations up to date?	☐ Yes ☐ No	Last Dental Exam	Glasses ☐ Yes ☐ No Braces ☐ Yes ☐ No
Pregnant	☐ No ☐ Yes, due date _____	Sexually Active If yes, use protection?	☐ Yes ☐ No ☐ Yes ☐ No

Headache/Migraine	☐ Yes ☐ No	Blood disorder	☐ Yes ☐ No
Seizure/Neurology	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Head trauma	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No
Sleep disorder	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Vision/Glaucoma	☐ Yes ☐ No	HIV/AIDS/STD	☐ Yes ☐ No
Heart disease	☐ Yes ☐ No	Nausea/vomiting	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Weight changes	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No	Chronic pain	☐ Yes ☐ No
Asthma/lung	☐ Yes ☐ No	Rheumatology problem	☐ Yes ☐ No

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Comments on above or other medical problems, any hospitalizations/surgeries (with dates & reasons), any other alternative medical treatments.
Please list any family members with a history of any of the above conditions:

Please list any recent laboratory studies (bloodwork, etc.)	

Please list any non-psychiatric medications (prescribed or non-prescribed such as vitamins, herbs, homeopathics)

DEVELOPMENTAL HISTORY *(for Child Patient/Clients ONLY. Adult Patients please skip & continue to Family History)*

During the patient/client's mother's pregnancy, did any of the following occur?

Inadequate prenatal care	☐ Yes	☐ No
Mother smoked, used drugs or alcohol	☐ Yes	☐ No
Mother used caffeine	☐ Yes	☐ No
Mother had emotional problems	☐ Yes	☐ No
Father used drugs or alcohol	☐ Yes	☐ No
Mother was a victim of violence	☐ Yes	☐ No
Mother had any illnesses, accidents, or stress	☐ Yes	☐ No

At time of delivery of client

Patient/Client was Full Term _____ or _____ Months				Birth Weight _____ lbs _____ oz	
Place of Delivery				Planned Pregnancy	☐ Yes ☐ No
Age of Mother		Age of Father		Marital Status (at time of delivery)	
Type of Delivery	☐ Normal ☐ C-Section, due to _____				
Duration of Labor	_____ hours	Any complications?	☐ No ☐ Yes, describe: _____		

While growing up, did the child patient/client have special problems, delays, or events regarding:

Holding head up	☐ Yes	☐ No	Potty training	☐ Yes	☐ No
Learning to bond	☐ Yes	☐ No	Feeding self with spoon	☐ Yes	☐ No
Learning to sit up alone	☐ Yes	☐ No	Tying shoes	☐ Yes	☐ No
Learning to crawl	☐ Yes	☐ No	Dressing independently	☐ Yes	☐ No
Sleeping through the night	☐ Yes	☐ No	Writing own name	☐ Yes	☐ No
Learning to walk	☐ Yes	☐ No	Ability to make/get along with friends	☐ Yes	☐ No
Learning to talk	☐ Yes	☐ No	Other		

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Family History & Living Situation

Who lives with the patient/client currently? List names and relation to patient/client (child, mother, father, etc.)	
What is the patient/client's birth order (e.g. 1st born child)?	
What are the patient/client's family strengths?	
How does the patient/client get along with above members of the family?	
How does/did the patient/client become disciplined for inappropriate behavior(s)?	
Any current conflicts or violence in the patient/client's home? Please describe.	
Did the patient/client ever witness or experience domestic violence in the past? ☐ No ☐ Yes	
If yes, please describe (physical / sexual / emotional / neglect):	
Was Child Protective Services ever involved in the patient/client's life? ☐ No ☐ Yes, please explain:	

Social Life / Friendship Relationships

What does the patient/client enjoy doing for leisure or recreation?	
Who are the current patient/client's friends and significant relationships?	
Current Status of patient/client	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Dating ☐ Other
Sexual Orientation *(optional)*	☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transsexual ☐ Other
"What are 3 things others like about you?"	1.
	2.
	3.
Any current relationship conflicts?	

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School History & Education

Highest Grade/Degree Completed		Current school *(if applicable)*	
Areas of academic struggle or learning difficulties			
Check any history of	☐ Special Ed services ☐ Special Classes ☐ IEP or 504 plan		
Describe recent significant changes in school grades (or GPA)			
Any history of truancy, school refusal, or suspensions/expulsions	☐ No ☐ Yes, please explain		
What are the client's future academic/career goals (*if not met yet*)			

Employment History / Means of Financial Support

What is the patient/client's (or child's caregiver's) current job?	
If unemployed, what was the most recent job of the patient/client (or child's caregiver) *(if applicable)*?	
Does the patient/client have a history of multiple job losses?	☐ Yes ☐ No
Is there any history of military services?	☐ No ☐ Yes, please describe: _____

Religious Affiliation / Activities *(Optional)*

Does the patient/client have any religious attachments or belong to any faith?	☐ No ☐ Yes, affiliation: _____
How has any religious/faith background or experience affected you (positively or negatively)?	

Juvenile Court or Legal History

Any history of Arrests or Offenses?	☐ Yes ☐ No
Any history of Tickets or Warnings?	☐ Yes ☐ No
Any history of Incarceration?	☐ Yes ☐ No
Any history of Placement outside the home?	☐ Yes ☐ No

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SUBSTANCE USE / ABUSE HISTORY

Please fill all applicable boxes in the chart below.

Substance	Never Used	Date Last Used	Period of Use (When to when)	Frequency (How often)	Amount Used per Occasion	How Used? (Inhaled, IV, Smoked, etc.)	Family History of Use?
Alcohol (include beers/coolers)							
Amphetamines (meth, crack, ice, etc.)							
Caffeine (beyond 16oz/daily) (coffee, tea, soda)							
Cocaine / Crack							
Ecstasy ("E") (MDMA)							
Hallucinogens (LSD, 'shrooms, peyote)							
Inhalants (glue, paint, aerosols, etc.)							
Marijuana							
Nicotine (cigarettes, cigars)							
Opiates (heroin, codeine, Vicodin, etc.)							
Over the Counter medications (diet pills, etc.)							
PCP							
Prescription Medications (not as prescribed – pain meds, etc.)							
Other							

Substance Abuse Treatment History *(if applicable)*	
Treatment Dates	
Name(s) of program or rehab center	

FOR OFFICE USE ONLY:
Intake questionnaire reviewed and confirmed with patient/client:
___ / ___ / ___ _____ (Date & Initials of evaluating clinician)