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*

4525 E. Atherton St., Long Beach, CA 90815 ● Tel. (562)961-0155 ● FAX (562)961-0161

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.

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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 Other:_____ Age: ____

Reason for Appointment: _____

Referred by: _____

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

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

Suicidal Thoughts: _____ Prior Suicide Attempts: _____

Emergency Contact: _____ Phone #: _____

Patient is Conserved: ◯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.

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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.

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Memorial Counseling Associates
Memorial Psychiatric Health Services

Appointment Reminder Policy

It is our company policy to contact every patient either the day before of 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

4525 E. Atherton St., Long Beach, CA 90815 ● Tel. (562)961-0155 ● FAX (562)961-0161

MEMORIAL COUNSELING ASSOCIATES Inc.

AUTHORIZATION/REFUSAL TO RELEASE MEDICAL INFORMATION

This authorization to receive or release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1980, Section 56 et. seq. of the California Civil Code.

☐ I **DO NOT** AUTHORIZE MY MEDICAL INFORMATION TO BE RELEASED FROM MEMORIAL COUNSELING ASSOCIATES

☐ I hereby **authorize** MEMORIAL COUNSELING ASSOCIATES
4525 E ATHERTON ST.
LONG BEACH, CA 90815
Phone: (562) 961-0155
Fax: (562) 961-0161

to furnish to NAME:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
PHONE: _____ FAX: _____

_____ *Initial here for mutual authorization for above parties to exchange information.*

Any/all records, including alcohol/drug abuse, psychiatric or psychological records, and any and all records pertaining to the testing and results of testing and treatment of HIV status or AIDS, pertaining to medical history and service rendered or treatment given to:

Patient Name:_____ SS#:_____

DURATION: This authorization shall be effective immediately and is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon.

I have carefully read and understand the foregoing. I consent to the release of the above specified information and/or medical records of my condition and the diagnosis and treatment which may include psychiatric illness, alcohol abuse and/or drug abuse to those persons of agencies listed.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

RESTRICTIONS: RELEASE OR TRANSFER OF THE SPECIFIED INFORMATION TO ANY PERSON OR ENTITY NOT SPECIFIED HEREIN IS PROHIBITED.

ADDITIONAL COPY: I understand that I have a right to receive a copy of this authorization at my request. Copy requested and received:
YES_____ NO_____, Initial_____.

Date Signed:_____. _____
[Patient, Parent, Guardian, or Authorized Representative]