SYDEA MEDICAL PRACTICE, INC

20311 SW BIRCH ST #100 NEWPORT BEACH, CA 92660*PHONE 949-345-5990*FAX 888-507-7138

PATIENT INITIAL EVALUATION FORMS

INITIAL EVALUATION MEDICAL AND PSYCHIATRIC HISTORY (PAGE 1 OF 2)
Patient's Name: ______________________________ Age: ________ Date of Birth: ______________
Sex: M F Marital Status: ______________________
Address:____
Phone #: _______________________________ Alternate #: __________________________________
Occupation: ____________________________
Education: (Highest level of education /degree /specialization) _______________________________
Primary Care Physician: (Name and phone number) ____
Emergency Contact: _____________________________ Phone #: ____________________________
Referral:____
Spiritual/Religious Background: ________________________
Please describe for reason for seeking treatment (include date/month the problem started):

____

____

____

Please indicate how the following symptoms/problems/complaints are effect you:
0) No effect 1) Little effect 2) Some effect 3) Much effect 4) Significant effect

______ Eating habits/Appetite: eating more or eating less: (circle one) binge or purge ______ Sleep: Trouble falling asleep; Trouble staying asleep; Trouble waking up; Avg # hours of sleep: _______ ______ Decreased Energy/Fatigue ______ Increased energy; hyperactivity ______ Sexual Functioning ______ Promiscuity ______ Loss of interest in activities ______ Mood Swings; depression or euphoria ______ Tearfulness ______ Racing Thoughts ______ Hopelessness/Helplessness ______ Spending Sprees ______ Decreased attention span ______ Engaging in reckless or impulsive behavior ______ Memory Difficulties: long term; short term ______ Talking too fast or too much ______ Irritability	______ Phobia: Fear of __________________________ ______ Anger outbursts ______ Impulse Control ______ Trouble Breathing ______ Hyperactivity ______ Flashbacks of traumatic event ______ Mood Changes ______ Nightmares ______ Anxious/Nervous ______ Obsessive/Recurring Thought ______ Worry/Fear ______ Hearing Voices ______ Rule breaking: stealing, lying, and cheating ______ Seeing things that are not there ______ Police/Probation involvement ______ Feeling paranoid

Patient Name: ____
Signature: ____ Date: __________________

INITIAL EVALUATION MEDICAL AND PSYCHIATRIC HISTORY (PAGE 2 OF 2)

Substance Use:

TYPE OF SUBSTANCE	LAST USE/ FREQUENCY/ FOR HOW LONG

Number of times Past treatment for substance use:
____

Do you smoke? Y N How much: ___________ Drink Coffee? Y N How much:_________________

Family history of substanceuse:____

Medical History: ____

ALLERGIES TO MEDICATIONS:____

Surgical History:____

Date of Last Physical: _______________ Date of Last Blood Work: _______________________

Current Medications: (Dosage, frequency, & prescribing M.D.)

____
____
____

Over the Counter Medications, Herbal Medicines, Supplements:
____

Are you currently taking any medications for Pain Management? Yes No

If yes, what medication? ____

Prescribing M.D. ___________________________

Psychiatric or psychological treatment of any kind before: Yes No

Therapist name and City/State: ____

Previous psychiatrists names city/state:____

Previous psych hospitalizations? Y N How many times?____________ Last time?______________

Previous names of psychiatric medication trials/ECT:____
____

Family history of psychiatric treatment (Please list which family member and type of treatment received):____
____

Female Life Cycle History:

Current # pregnancies ________ Are you planning for pregnancy? Yes No If yes when? ____________

When was your last menstrual period? _____________ Are you currently using any form of birth control or hormonal medication? If Yes, What?____

Patient Name: ____

Signature: ____ Date: _________________

DISCLOSURE STATEMENTS AND ASSIGNMENT OF BENEFITS (PAGE 1 OF 2)

1. CONFIDENTIALITY I understand that all information between myself and my provider is held strictly confidential and no information about my psychiatric service including diagnosis, treatment, prognosis, progress or any other confidential information will be released unless permitted by law or:
1. I agree in writing to permit such a release,
2. I present a physical danger to myself,
3. I present a danger to others,
4. Child/Elder abuse or neglect is suspected,

I understand that in care 2, 3 and 4, Dr. Sanchez is required by law to inform potential victims and legal authorities so that protective measures can be taken. (Please initial) _________

2. RELEASE OF INFORMATION In addition to releases of information permitted above, I authorize discussion of my case with the referral source and other health care providers and facilities for purposes of diagnosis and treatment. (Release of information to providers, family, etc., requires separate form). (Please initial) _____________

3. GENERAL CONSENT FOR TREATMENT I further authorize and request that my physician carry our psychological examinations, treatments, and or/diagnostic procedures, which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult. I understand that my provider will keep a clinical record that will contain information regarding my diagnosis, treatment, prognosis, progress, and other documents pertinent to my treatment. This record is confidential and will only be released with my written consent except in cases detailed under “Privacy Practices.” (Please initial) _____________

4. EMERGENCY PROCEDURES I understand that my provider, Venice Sanchez M.D. may not be available for emergencies. If I need to contact my provider, I will leave a message according to the instructions on my provider’s confidential voice mail and my call will be returned. If an emergency situation arises, I will follow the emergency procedures listed on my provider’s voice mail message. If my call is not promptly returned and I require immediate attention, I will call 911 or go to my nearest Emergency Room. I will do this for true emergencies only. (Please initial) ____________

5.RESPONSIBILITY OF PAYMENT: I understand that I am responsible to pay for my doctor’s visit. In the case that my insurance does not pay for my visit, I understand that it is my responsibility to pay for the visit. I am responsible to pay for copay, coinsurance and fees if my deductible has not been met. $200 for initial visit, $85 for follow up. I understand that I can call my insurance company to find out more information. (Please initial) ____________

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6. CANCELLATION /MISSED APPOINTMENT FEES: I understand that I will be charged $50 for any missed appointments or appointments in which I do not cancel at least 24 hours prior to my scheduled appointment. I understand that it is my responsibility to remember my appointment. It is not the responsibility of Dr. Sanchez or her staff to remind me of my appointment. (Please initial) ____________

7. FEES FOR FORMS, LETTERS, AND PHONE CALLS I understand that I will be billed $50 per set of initial disability paperwork, $75 for extensive disability paperwork and $25 for disability renewals and updates. There is a $25 fee for all letters. I understand that I will be billed a prorated amount for all phone calls lasting longer than 5 minutes. (Please initial) ____________

8. PRESCRIPTION REFILL REQUESTS If you are prescribed medications, it is imperative that you attend visits on a regular basis for your providers to monitor your progress and potential side effects. I understand that refills will not be provided unless I have made a follow up appointment with Dr. Sanchez to monitor my progress. (Please initial) ________________

9. PRIVACY PRACTICES I have received notice of my provider's privacy practices and have read, reviewed and am aware of privacy practices of this office.

I have read and I understand the policies listed above:

Patient Name ____

Signature___________________________________Date____________________

TELEMEDICINE CONSENT FORM

Ryan Wright M.D.
20311 SW Birch St. Ste #100 Newport Beach, Ca 92660
Phone: 949-226-1715 Fax: 949-861-6428

Venice Sanchez M.D.
20311 SW Birch St. Ste#100 Newport Beach CA 92660
Phone: 949-345-5990 Fax: 888-507-7138

I hereby authorize Dr. Ryan Wright or Dr. Venice Sanchez to use telemedicine in the course of my diagnosis and treatment. I understand that telemedicine involves the communication of my medical information, both orally and visually, to physicians and other health care practitioners located in other parts of the state or outside of the state.

I understand I have all the following rights with respect to telemedicine:

1) Patient Choice of Care. I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future care or treatment and without risking the loss of my health coverage.

2) Access to Information. I have the right to inspect all medical information transmitted during a telemedicine consultation; and may receive copies of this information for a reasonable fee.

3) Confidentiality. I understand that the laws which protect the confidentiality of medical information apply to telemedicine; and that no information or images from the telemedicine interaction which identify me will be disclosed to researchers or other entities without my consent.

Potential Risks. I understand that there are risks from telemedicine, including the possibility,

despite reasonable and appropriate efforts, that: the transmission of medical information could be disrupted or distorted by technical failures in transmission; the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage or medical information generated by this telemedicine consultation in one or more databases could be accessed by unauthorized persons. In addition, I understand that telemedical examinations or care may not be as complete as face-to-face examinations or care and that telemedicine does not negate or minimize the risks that may be inherent in a medical illness

or condition. Finally, I understand that it is impossible to list every possible risk, that my condition may not be cured or improved, and in rare cases, may get worse.

Consequences. I understand that by consenting to telemedicine my physician will communicate medical information concerning me to physicians and other health care practitioners located in other parts of the state or outside the state.

Benefits. I understand that I can expect benefits from telemedicine, but that no results can be guaranteed or assured. Telemedicine provides me with access to medical care that otherwise would not have been available in my community.

________________Patient Initials ____________Date

I have read and understand the information provided above, I have discussed it with my physician or my physician's designee, and all my questions have been answered to my satisfaction. I choose to have my care delivered through telemedicine and hereby release my physician from any responsibility whatsoever for unfavorable or untoward results which I understand may occur as a result of my decision to receive my care through telemedicine. !

____Print name

____Signature

____Date

Address of Patient:

____

____

____

Credit card Authorization
Venice Sanchez, M.D.

Venice Sanchez, M.D. accepts MasterCard, Visa, Discover, and American Express for payment of fees. To pay fees using credit card or debit card simply complete and sign this form.

Patient Name: ____

I _________________________________ authorize Dr. Venice Sanchez to charge the following credit/debit card (Check One):

☐ **MasterCard** ☐ **Visa** ☐ **Discover** ☐ **American Express**

A $50.00 fee will be charged for missed psychiatric appointments or psychiatric appointments not cancelled within 24 hours of appointment.

Name on Credit/Debit card: _____________________________

Credit/Debit Card #: __________________________________

Expiration Date: ____________ CCV: ____________

Billing Address: __________________________________

____

Signature:_________________________________

20311 SW Birch St. Suite 100, Newport Beach, CA 92660
Office Phone: 949-345-5990 | Office Fax: 888-507-7138