FOR PROVIDER USE ONLY

DX:

Joshua M.H. Hall, M.D., Ph.D.
15525 Pomerado Road, Suite E-3, Poway, CA 92064
Phone 858-592-6644 Fax 858-592-6393

PATIENT INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME		
BIRTH DATE	AGE	SEX	MARITAL STATUS	
		☐ M ☐F	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐SEPARATED ☐WIDOWED	
MAILING ADDRESS		CITY	STATE	ZIP
HOME PHONE	MOBILE PHONE	EMAIL		
( )	( )			
SOCIAL SECURITY #	EMPLOYER	PREFERRED CONTACT NUMBER		
		☐ HOME ☐ MOBILE		
PRIMARY CARE PHYSICIAN	PHONE	MAY WE CONTACT THIS PERSON?		
	( )	☐ YES ☐NO		
REFERRED BY	PHONE	MAY WE CONTACT THIS PERSON?		
	( )	☐ YES ☐NO		

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT)

FIRST NAME	MIDDLE NAME	LAST NAME		
BILLING ADDRESS		CITY	STATE	ZIP
HOME PHONE	MOBILE PHONE	EMAIL		
( )	( )			
SOCIAL SECURITY #	RELATIONSHIP TO PATIENT			
	☐ SPOUSE ☐ PARENT ☐ OTHER_____			

EMERGENCY CONTACT INFORMATION

NAME		RELATIONSHIP TO PATIENT
HOME PHONE	MOBILE PHONE	
( )	( )	

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARDS TO BE COPIED)

☐ PLEASE CHECK HERE IF YOU HAVE NO INSURANCE AND YOU WILL BE SOLELY RESPONSIBLE FOR PAYMENT.

PRIMARY INSURANCE		SECONDARY INSURANCE	
SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE	SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE
SUBSCRIBER ID #	GROUP #	SUBSCRIBER ID #	GROUP #
SUBSCRIBER EMPLOYER	RELATIONSHIP TO PATIENT ☐ SPOUSE ☐PARENT ☐OTHER	SUBSCRIBER EMPLOYER	RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐PARENT ☐OTHER

I hereby authorize my insurance companies to pay directly to Joshua M.H. Hall, M.D., Ph.D. insurance payment otherwise payable to me for services rendered. I also authorize the doctor to release any information requested by the above named insurance companies that might be needed to process this claim.

I understand that I am financially responsible for all charges whether or not they are covered by insurance and for missed appointments and cancellations with less than 24 hours notice. In the event of default, I agree to pay all costs of collection, including collection agency fees and reasonable attorney fees, and acknowledge my account may be subject to a 1.5% monthly interest fee for delinquent charges.

I have read and understand the Office Policies and Consent for Treatment and do so agree to these conditions.

SIGNATURE_____ DATE_____

OFFICE POLICIES AND CONSENT FOR TREATMENT

I, _____ (the patient), authorize and request that Joshua M.H. Hall, M.D., Ph.D. (the physician), provide evaluation and treatment services which now, or during the course of my care, are advisable. The frequency and type of treatment will be decided between my physician and me. Psychiatric evaluations last for 45-60 minutes. Follow up visits vary in length: 10-15 minutes for routine medication management and either 30 or 45 minutes therapy or complicated medication management sessions. I understand that there is every hope that I will benefit from treatment but there is no guarantee that this will occur. I recognize that modern psychiatric medication treatment includes risk of common side effects and the possibility of serious harm or even remote risk of death. I understand that maximum benefit and safety will most likely occur with consistent follow up, following recommendations, and that no treatment or a trial off medication is always a treatment option.

PAYMENT OF FEES: Payment for services is the patient's responsibility at the time of service. I agree to pay my share of charges, such as co-payments and deductible amounts at the time of each visit. I agree to notify the physician or his office during the course of treatment if problems arise regarding my ability to make timely payments or if my insurance coverage changes. The charge for each appointment depends upon the time I spend with the physician and the type of visit for which I am seen. I understand that the physician's fees are within the usual and customary rates for medical services in the San Diego area. For specific dollar amounts, please ask the office staff. There is a $25 service fee for all returned checks. Delinquent accounts (greater than 90 days) will be charged a 1.5% monthly interest fee.

NON-CLINICAL SERVICES: I understand that the physician is available to provide services not related to direct patient care. These services may include disability paperwork completion, letters, phone calls to family members or other communications or services requested. These services are not covered by insurance and will be billed at a rate of $65 per ten (10) minute increment.

APPOINTMENTS: Scheduling of an appointment involves reservation of a time specifically for me. I agree to pay a $100 fee for a missed appointment or cancellation with less than 24 hours notice. I understand that insurance companies do not pay for missed appointments.

MEDICATION REFILLS: The minimum visit frequency is six months to be prescribed any medications by the physician (4 months for controlled substances and 2 months for stimulants). If I have not been seen within that amount of time, I understand that refill requests will be denied until I attend an appointment with the physician. The physician will respond to refill requests from either myself or my pharmacy on days that he is in the office (currently Monday, Wednesday and Thursday). I understand that it is my responsibility to request a refill with enough advance notice to not run out of medication. If I need a refill done on a day the physician is not in the office, I agree to pay a $25 up-front fee for that refill.

INSURANCE: This office will submit insurance claims to my carrier at no cost to me. However, neither the physician nor the billing service is in a position to guarantee payment from my insurance company since the claim is based upon agreements between me and my insurer. I understand that I am responsible for any services not paid by the insurance company, including charges for missed appointments.

PROTECTED HEALTH INFORMATION: My "protected health information" means health information, including my demographic information, collected from me and created or received by this provider, another health care provider, a health plan, my employer or a healthcare clearinghouse. The protected health information relates to my past, present, or future physical health, mental health or condition and identifies me, or provides a reasonable basis to believe the information may identify me.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of this medical practice. The physician is not required to agree to the restrictions that I may request. However, if the physician agrees to any requested restriction, then this restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that the physician has taken action in reliance on this consent.

I understand that I have a right to review the physician's Notice of Privacy Practices prior to signing this document. This Notice of Privacy Practices is available on request of the office staff.
The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and the duties with respect to my protected health information.
I understand that the physician reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by requesting it in writing or at my next appointment.

CONFIDENTIALITY: Professional ethics and California state law specifies that communications to medical staff are confidential and may not be released or shared without the expressed written permission of the patient, except as noted above or in the Notice of Privacy Practices. Disclosure may be required or permitted in the following circumstances:

1. When there is a reasonable suspicion of child abuse or abuse to a dependent or elder adult.
2. When the patient communicates a threat of bodily injury to others.
3. When the patient is suicidal.
4. Physical injury due to violence.
5. To appropriately coordinate treatment with the referral source and/or primary care physician or other medical or mental health treatment providers involved in the patient's care.

Consultation with the physician's professional colleagues uninvolved in my care may occur. In such cases, neither my name nor any identifying information will be revealed.

ELECTRONIC COMMUNICATION: I understand that the physician does not communicate with patients via email or text messaging. Non-clinical communication (e.g. scheduling and appointment reminders) with office staff may occur electronically and by engaging in this type of communication I acknowledge that this is a non-private means of communication and waive any right to privacy of the transmitted information.

EMERGENCY PROCEDURES: **Call 911 for any life-threatening emergency**. If contact with the physician is necessary between appointments, please leave a message with the office staff or voice mail system by dialing 858-592-6644 and your call will be returned in a timely manner. If an emergency situation arises, inform the office staff or the answering service that your call is an emergency. The staff or service will make every effort to reach the physician or covering clinician. When the physician is out of town or otherwise unavailable, a qualified professional will provide coverage.

I understand that this treatment consent is an agreement between me and Dr. Joshua M.H. Hall, M.D., Ph.D., sole proprietor. Psychiatric and Behavioral Health is a collection of independent providers that share office space and certain expenses, but is not a group medical practice. Poway TMS, LLC is a business services company and is not a medical practice or professional provider.

Please do not hesitate to contact the physician, the office staff, or your insurance provider if you have questions or concerns about your care and/or treatment.

I HAVE READ AND UNDERSTAND THESE OFFICE POLICIES.

_____ _____

Patient Signature Date

Page 3 (summary of policies) was given to the patient. _____

Staff initials

TAKEAWAY POINTS FROM OFFICE POLICIES AND CONSENT FOR TREATMENT:

- Psychiatric treatment (like any medical treatment) involves potential benefits and risks
- Fees for services and copays are due at the time of service
- Missed appointments or late cancellations are charged $100
- Fees for non-clinical services (such as completing disability forms, letters, and talking to family members) are $65 per 10 minutes
- Refills done on non-office days are $25 each
- Minimum visit frequency is 6 months in order to be continued on any medications (4 months for controlled substances, 2 months for stimulants)
- Treatment is confidential and privacy will be protected per federal and state law
- Dr. Hall does not communicate with patients via email or text messaging
- Dr. Hall is a solo practitioner, not part of a group practice

TELEPSYCHIATRY CONSENT FORM

Telepsychiatry provides psychiatric services using interactive video conferencing tools in which the psychiatrist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care without the need to visit the office or travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in errors in medical judgment. Alternatives to telepsychiatry include traditional face to face sessions.

MY RIGHTS:

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
2. I understand that the telemedicine platform (doxy.me) is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. You can review the security features of doxy.me at https://help.doxy.me
3. I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time.
4. I understand that Dr. Hall has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time.
5. I understand that all rules and regulations that apply to the practice of medicine in the State of California also apply to telepsychiatry. As of January 2020, the restriction from prescribing controlled substances without an in-person visit has been waived by the DEA. When this restriction goes back into effect, no controlled substances will be prescribed without an in-person visit.

MY RESPONSIBILITIES:

1. I will log in to Dr. Hall's virtual waiting room (https://doxy.me/drhall92064) at or before my scheduled appointment time. There is not a prompt or invitation to log in, though office staff typically send appointment reminders before the appointment. Failure to log in during the appointment time will be considered a no-show to the appointment and charged accordingly. I will ensure that I have an adequate internet connection and equipment to do the video visit before the appointment.
2. I will conduct the visit from a safe, secure location that meets my personal needs for privacy of the visit. If I am in a vehicle, it will be stationary (parked) and I will inform Dr. Hall of my location at the start of the visit.
3. I will not record any telepsychiatry sessions without the prior written consent of Dr. Hall and I understand that Dr. Hall will not record telepsychiatry sessions without my consent.
4. For privacy protection, I will inform Dr. Hall if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Hall will inform me if any other person can hear or see any part of the session before the session begins.
5. I understand that I MUST be a resident of California to be eligible for telepsychiatry services from Dr. Hall.

My signature below indicates that I have read and understand the information provided above regarding telepsychiatry, and that I authorize Dr. Joshua M.H. Hall, M.D., Ph.D. to use telepsychiatry for diagnosis and treatment.

_____ _____

Patient Signature Date