V. Depala, MD

27349 Jefferson Ave, # 109
Temecula CA 92590

613 South Howard
Corona, CA 92879

Patient Registration Form

Last Name:_____First Name:_____M.I:_____

Date of Birth:_____/_____/_____ Patient Social Security#:_____-_____-_____

Home Address_____ City:_____ Zip:____

Home Phone(____)_____-_____ Cell Phone(____)_____-_____

Which number is the best to reach you at? Home Cell

May we leave medical/appointment related information on voicemail? Yes_____ No _____

Emergency contact:_____Relationship to you:_____

Phone: (____)_____-_____Address:_____

City:_____State:_____Zip Code:_____

May we discuss your case with them? Initial Yes ____ No ____

Current Medical Conditions

Condition/illness	Medications	Dose	Doctor	Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been hospitalized for emotional reasons? Yes No

Allergies: None _____

Insurance Information

Health Insurance Carrier:_____ Ph : (____)_____-_____
Subscriber ID: _____ Plan#:_____ Group#:_____
Name of Insured:_____
Insured's Birth date: ____/____/_____Insured's Social Security #:_____-_____-_____
Relationship to patient: _____Insured Employer_____
Who referred you to our clinic?_____

I understand that I am ultimately responsible for the payment of my bill including late cancellations, un-cancelled/no-show appointments, service charges, etc. and I consent to allow any contracting clinicians with Venugopal Depala, M.D. have access to my chart. I understand that the information provided above is accurate to the best of my knowledge.

Signature:_____ Date:_____

Assignment of Benefits:
I authorize and direct my insurance company to make payment directly to my clinician for services rendered. I agree to be financially responsible for charges not covered by this authorization. I authorize my clinician to furnish information to the payer for purposes of obtaining reimbursement.
Signature: _____ Date:_____

(For Physician Only)
I have reviewed above patient data with the patient and/or guardian.
Signature_____Date:_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

This is to authorize Venugopal Depala MD, to exchange any and all medical information (please include lab work) concerning my illness(es) and any additional information pertaining the to the diagnosis and treatment of mental illness, substance abuse and/or alcohol abuse with the following (include name(s), address(es), phone number(s), fax number(s), of practitioner(s):

Primary MD:_____
_____
Therapist (if any):_____
_____
Other:_____

- **Please print patient's name here:**

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, becomes effective on the date signed and may be revoked by me at any time. If not earlier revoked or instructed, this authorization shall terminate automatically when treatment with our clinic is terminated. I understand that the information authorized by this release will be provided to the authorized recipient(s) only. I further understand that I have a right to receive a copy of this authorization upon my request.

I choose not to authorize release of my treatment information

Signed: Date:

Relationship to the patient:

Patient's Birthdate: Phone:

Note to Health Care Practitioner(s): this patient began treatment on ____/____/____.
The diagnosis is:

Medications and dosages include:

*We need you to also send us a full physical exam, lab work, and any other findings related to patients care. …And thank you for your referrals!

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BUSINESS ARRANGEMENTS

CANCELLATION OF APPOINTMENTS:

When you make an appointment, time is reserved especially for you. If you cancel or reschedule more than 24 hours ahead of time you will not be charged. However, **if you cancel or reschedule less than 24 hours in advance, or simply no-show, it is not possible to offer the time to someone else, and you are charged 100% of your fee**. (You can leave a message on my voice mail which records the time of the call). Insurance companies do not reimburse for late cancellations and "no shows."

If you are scheduled for an appointment and are late by 10 minutes or more, we will consider you a no show and you will be charged 100% of your fee.

PAYMENT OF FEES: **We accept checks or credit cards (Visa and Master Card)**

For those with insurance benefits, the billing service will obtain information regarding your co-pay and/or deductible. If you have arranged for this prior to our 1st appointment, you will only be responsible for the co-payment. **It is expected that co-pays will be made at each appointment.** Again, you are ultimately responsible for the payment of all fees. If your account goes unpaid we reserve the right to utilize a collection agency for any unpaid fees.

SCHEDULE OF FEES

Note: the prices shown below are the charges billed to your insurance company. You are responsible for any co pay/coinsurance amounts not paid for by your insurance.

Initial Evaluation	$250
Follow up Visit	$150

Note: (The following fees are not covered by insurances and are your responsibility):

Due to the time constraints of filling out forms, please allow 3 business days for the completion forms and prescription refills.

Forms, Letters, other activities occurring beyond scheduled sessions, a balance overdue of 60 days or more	$40.00
Chart copies to the patient	$0.10 page + clerical charges

Patient Signature: Date:

Print Patient Name:

Guardian Signature**:** Date:

Guardian Print Name: Date:

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Due to the time constraints of filing out forms, please allow 7 -10 business days for the completion forms and at least 3 days for prescription refills.

Forms, Letters, other activities occurring beyond scheduled sessions, a balance overdue of 60 days or more	$40.00
Forms requiring extensive information	$80.00
Chart copies to the patient	$20.00

CONFIDENTIALITY: For practitioners and psychotherapists:

If someone should call to inquire about you, no communication with that person will be made without your permission. There are certain exceptions to your privacy and confidentiality that are bound by legal matters that are designed to provide safety to you and those around you. These exceptions are:

1. Tarasoff-Civil Code 43.92: If you threaten to endanger any identifiable person(s), all practitioners are bound by law to contact any law enforcement and the potential victims.

2. Penal Code 111166: If the practitioner suspects any evidence of child abuse or neglect, they must contact he appropriate authority and submit a written report within 36 hours to that authority.

3. California Welfare and Institutions Codes 15600-15755: If any elderly person age 65 or older or person between the ages of 18-64 is under the care of another person for their mental/physical well-being, the practitioner is mandated to inform the appropriate authorities should there be suspect of sexual or physical abuse, abandonment, neglect, or fiduciary abuse/neglect.

4. Evidence Code 1024: A practitioner is permitted to breach contract of confidentiality if the client's mental or emotional state shows the potential to harm oneself, another person, or property of another.

By initialing below, you are consenting to a referral for psychotherapy:

Please initial _____Yes _____No

I have read and understood the above agreement, if I have any questions or concerns I understand I have the right to discuss them with my healthcare provider or contact my insurance carrier.

Patient Signature: Date:

Print Patient Name:

Guardian Signature**:** Date:

Guardian Print Name: Date:

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I, _____ am fully aware that I am responsible for any payment that has not been covered by my insurance company. The office will get eligibility and benefits and bill my insurance and I will be finally responsible towards any copay's/deductible/other payments not covered by my insurance carrier. I understand that the office is not responsible for any information provided incorrectly by my insurance company.

I, _____ have been advised in advance that if I cancel my appointment with less than 24 hour notice, I will be charged the full appointment fee up to $150 for the missed appointment. I am in agreement with this policy and all questions have been answered. As a courtesy, I will be called at this phone number, _____
to be reminded prior to the appointment, but it is totally my responsibility to remember and write down the appointment.

Please help yourself by keeping your appointment, it is your mental health. We are only here to help.

Patient Name: _____

Responsible Party Name: _____

Responsible Party Signature: _____

Date: _____

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Controlled Medication Policy

It is the policy of **Venugopal Depala M.D.**, INC to closely monitor the use of controlled medications prescribed to our patients. These medications include, but are not limited to, benzodiazepines, stimulants, sleep medication, pain medication and addiction medication. These medications carry a risk of addiction, often used illegally and, if not managed appropriately, may cause serious injury and/or death. If I am prescribed Medication Assisted Treatment (for example Buprenorphine treatment): I agree to keep, and be on time to, all my scheduled appointments. I agree to conduct myself in a courteous manner in the doctor's office. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/ prescription until the next scheduled visit. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
I understand that mixing this medicine with other medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax), can be dangerous. I agree to read the Medication Guide and consult my doctor should I have any questions or experience any adverse events. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances. I agree to provide random urine samples and have my provider test my blood alcohol level. I understand that any violations to the above may be grounds for immediate termination of treatment.

I have read and understood the above agreement, if I have any questions or concerns I understand I have the right to discuss them with my healthcare provider.

Patient Signature: Date:

Print Patient Name:

Guardian Signature**:** Date:

Guardian Print Name: Date:

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Informed Consent for Treatment & Medication

I _____, agree and consent to participate in behavioral health care services offered and provided at/by Dr. V. Depala, a behavioral healthcare provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral healthcare providers directly supervising the services received by the patient. If the patient is under age 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual. I have been provided education on my primary diagnosis.

Dr. V. Depala has educated me regarding the medication that has been prescribed to (please check one of the following) _____me, _____my child, or _____a person for whom I am the legal guardian, and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication and the possible effects of this medication if the person taking this medication becomes pregnant (including discussing with my doctor my desire to become pregnant or breastfeed before becoming pregnant). I have also been informed of the reason or purpose for which this medication was prescribed.

Patient Name: _____

Patient/Legal Guardian Signature: _____

Date:_____

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PARENT AUTHORIZATION FOR EXAMINATION OF A MINOR

I hereby give authorization to V. Depala M.D, to administer evaluation/medication management/psychotherapy/psycho pharmacotherapy to:

PRINT MINOR'S NAME: _____

The purpose of evaluation/psychotherapy/psycho pharmacotherapy is for the child's benefit.
It is my understanding that such information will be kept confidential and will be used for professional purposes only.

_____ _____
Parent Signature Relationship to minor

_____ _____
Parent Signature Relationship to minor

_____
Date signed