



HARBOR PSYCHIATRY & MENTAL HEALTH

4631 Teller Ave #100 Newport Beach, CA 92660 Phone: 949-887-7187 Fax 949-476-3080

PATIENT REGISTRATION INFORMATION

Patient's Last Name: _____ Patients First Name: _____

Date of Birth: _____ Sex: Male/Female Marital Status: _____

Full SSN: _____ Phone #: _____

Full Home Address: _____

(Street/City/State/Zip Code)

Do you consent to receive automated reminder calls at this phone number? Yes/ No

If Yes, please sign _____

Email: _____

Do you consent to allowing any/ all communication (medical &/or mental documentation, billing statements and financial information) being sent to the email address above? Yes / No

Emergency Contact: _____ Phone #: _____

Relation to Patient: _____

Preferred Pharmacy: _____

(Name/ Location/Phone #)

How did you hear about our clinic?

INSURANCE INFORMATION

(Please give your insurance card & driver's license to receptionist)

Person responsible for bill: _____ DOB: _____

Address: _____ Phone #: _____

PRIMARY INSURANCE

Insurance Company: _____ Member/Subscriber ID: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Subscriber's SSN: _____ DOB: _____ Copayment \$ _____

Policy #: _____ Auth#: _____

if applicable CalOptima/MediCal Members Only

SECONDARY INSURANCE if APPLICABLE

Insurance Company: _____ Member/Subscriber ID: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Subscriber's SSN: _____ DOB: _____ Copayment \$ _____

Policy #: _____



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NOTICE OF PRIVACY PRACTICES - Psychology & Psychiatry Services

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.

The following information provides details about the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and your rights concerning privacy and your psychological records. HIPAA requires that we provide you with a Notice of Privacy Practices for treatment, payment and health care operations. The law requires that we obtain your signature acknowledging that we have provided or offered you this information.

Disclosures for treatment, payment, and healthcare operation

We may use or disclose your **protected health information (PHI)**, for certain treatment, payment, and health care operations purposes without your authorization. In certain circumstances we can only do so when the person or business requesting your PHI gives us a written request that includes certain promises regarding protecting the confidentiality of your PHI.

Uses/disclosures requiring authorization

We may use or disclose the minimum necessary PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when we asked for information for purposes outside of treatment and payment operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy & medication management notes. These are notes we have made about our conversation during a private, group, joint, or family therapy session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until we receive it. When the state (California) laws are more protective than HIPAA, the more stringent requirements will apply.

Possible uses with neither consent nor authorization

We may use or disclose the minimum necessary PHI without your consent or authorization in the following circumstances:

. **Child Abuse:** Whenever we, in our professional capacity, have knowledge of or observe a child, or reasonably suspect, a child under age 18 has been the victim of abuse or neglect, we must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if we have knowledge of or reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, we may report such to the above agencies.

. **Elder and Dependent Adult Abuse:** If we, in our professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if we are told by an elder or dependent adult that he or she has experienced these or if we reasonably suspect such, we must report the known or suspected abuse immediately to the adult protective services agency or the local law enforcement agency.



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We do not have to report such an incident if:

- 1) We have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;
 - 2) We are not aware of any independent evidence that corroborates the statement that the abuse has occurred;
 - 3) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and
 - 4) In the exercise of clinical judgment, we reasonably believe that the abuse did not occur.
- **Serious Threat to Health or Safety:** If you or your family member communicate to me that you pose a serious threat of physical violence against an identifiable victim, we must make reasonable efforts to communicate that information to the potential victim and the police. If we have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, we may release relevant information as necessary to prevent the threatened danger.
 - **Health Oversight:** If a complaint is filed against us with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.
 - **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that we have provided you, we must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides us with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified us that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. We will inform you in advance if this is the case.
 - **Worker's Compensation:** If you file a worker's compensation claim, we may disclose to your employer your medical information created as a result of employment-related health care services provided to you at the specific prior written consent and expense of your employer so long as the requested information is relevant to your claim provided that is only used or disclosed in connection with your claim and describes your functional limitations provided that no statement of medical cause is included.

Your rights regarding your protected health information (PHI)

. **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to all restrictions you request. An important exception is your right to request non-disclosure to your health plan for which you pay out-of-pocket unless the disclosure is for treatment purposes or in the rare event disclosure is required by law.

. **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your bills to another address.)

. **Right to Inspect and Copy** – You have the right with your written request to inspect or obtain a copy (or both) of PHI and/or psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will have 30 days to respond to your request with one 30-day extension and will discuss with you the details of the request and denial process. There will be a small charge to cover the cost of paper copies and labor. We must provide you access to electronic health records and other electronic records in the electronic form and format requested by the individual if the records are readily reproducible in that format. Otherwise, we must provide the records in another mutually agreeable electronic format. Hard copies are permitted only when you reject all readily reproducible e-formats.



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. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, we will discuss with you the details of the accounting process.

. *Right to Prohibit the Sale of PHI* – Your absence of a written authorization means you are prohibiting the sale of your PHI. Marketing or research uses would be examples of reasons to sell PHI.

. *Right to a Paper Copy* – You have the right to obtain a paper copy of the HIPAA Notice from me upon request, even if you have agreed to receive the Notice electronically.

Psychologist's/ Physician's Duties

. We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

. We must notify you if unsecured PHI is breached. Because your PHI will be encrypted, no notification will be required. No risk assessment of unsecured PHI will need to be conducted if notification of a breach is made. . We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

. We are allowed to send unencrypted emails if you are advised of the risk and still request that form of transmission.

. We are allowed to make relevant disclosures to your family after death under essentially the same circumstances such disclosures were permitted before death.

. We are allowed to tell you about a third-party product or service without your written authorization when: we receive no compensation for that product or service, our communication with you is face to face, it involves general health promotion, and/or it involves government or government-sponsored programs.

. If we revise my policies and practices (indicated in the HIPAA Notice), we will provide current clients with a revised notice, at their request, in person or by mail to their home address. All new clients receive a copy during their first session.

Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Harbor Psychiatry and Mental Health at (949) 887-7187.

I have read and understand the above Notice of Privacy Practices.

Patient/Parent/Guardian Signature

Please print name

Date



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Welcome to our Practice

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about their procedures, they should be discussed whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

THERAPY APPOINTMENTS

As a typical rule, we will be reserving one (1) hour per week (or as often as the treatment plan prescribes) to hold your place. If you need to cancel or reschedule a session, we ask that you provide us with a minimum of 24-hours' notice. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for arriving for your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES FOR MEDICATION MANAGERMENTS

The standard fee for the initial visit with an MD (without insurance) is \$600.00, and each subsequent visit is \$200.00. The standard fee for the initial visit with a PA/NP (without insurance) is \$450.00, and each subsequent visit is \$150.00. You are responsible for paying at the time of your appointment unless prior arrangements have been made. Any checks returned by your bank as unpayable are subject to an additional fee of \$25.00 to cover bank fees that we incur. If you refuse to pay your debt, we reserve the right to use an attorney/ collections agency to secure payments.

PROFESSIONAL FEES FOR THERAPY

The standard fee for a 1-hour initial visit (without insurance) is \$250.00, and each subsequent visit is \$200.00. The standard fee for a 40-minute initial visit (without insurance) is \$200.00, and each subsequent visit is \$150.00.



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You are responsible for paying at the time of your appointment unless prior arrangements have been made. Any checks returned by your bank as unpayable are subject to an additional fee of \$25.00 to cover bank fees that we incur. If you refuse to pay your debt, we reserve the right to use an attorney/ collections agency to secure payments.

PRORATED FEES

In addition to weekly appointments, it is our practice to charge this amount on a prorated basis (we will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other services which you may request of your therapist. If you anticipate becoming involved in a court case, we recommend that we discuss this fully before you waive your right to confidentiality. If your case requires our participation, you will be expected to pay for the professional time required even if another party compels testimony.

CONFIDENTIALITY/ NOTICE OF PRIVACY PRACTICE

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. If you would like a complete copy of this, please ask at the front desk. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a licensed clinical psychologist. In most situations, a psychologist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. However, there are some situations in which a psychologist may be permitted or required to disclose information without the patient's consent or authorization. These situations include:

1. If there is a reasonable suspicion or evidence that a child under age 18 is suffering or has been the victim of child abuse (including sexual and physical abuse, and neglect), the law requires that a report be filed with the appropriate governmental agency (Child Protective Services) and legal authorities. A report may also be made if we know or reasonably suspect emotional abuse of mental suffering inflicted upon a child.
2. If we have reasonable suspicion or evidence that an elder or dependent adult is suffering or has been the victim of abuse (including sexual, physical, emotional and financial abuse, neglect, abandonment, abduction, isolation), the law requires that we report to legal authorities and/or the State Department of Social Services.
3. If a patient (or a family member of the patient) communicates an imminent threat of physical violence against an identifiable victim (the patient's intent to harm or plan to harm), we are required to take protective actions including notifying the potential victim (s), and contacting the police. We may also seek hospitalization for the patient.



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4. If a patient communicates intent and/or a plan to harm himself/herself (commit suicide), we are required to notify legal authorities and make reasonable attempts to protect the patient including seeking hospitalization and notify family members who can help provide protection.

CONTACTING YOUR PSYCHIATRIST/ THERAPIST

Your psychiatrist/ therapist may often not be immediately available by telephone. They will not answer their phones when they are with clients or otherwise unavailable. At these times, you may leave a message or send an email and your call/ email will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear back from or they are unable to reach you, and you feel you cannot wait for a return call or email, or if you feel unable to keep yourself safe, go to your local Hospital Emergency Room or call 9-1-1 and ask to speak to the mental health worker on call.

Initials ----- **NO-SHOW or CANCELLATION**

If you miss an appointment without canceling or cancel with less than a 24-hour notice, the policy is to collect a \$50 or \$75 fee (unless it is agreed that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for **canceled** sessions; thus you will be responsible for the fee described above.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I ; _____

HEREBY AUTHORIZE: Providers at Harbor Psychiatry & Mental Health TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- . Information related to the scheduling of meetings or other appointments
- . Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that this authorization will terminate at the end of my treatment or I may terminate this authorization at any time.

CONSENT FOR PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

I understand & agree to the clinic policy with regards to missed appointments and outstanding balances

Signature of Patient/Representative

Date

Printed Name of Patient/ Representative



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Permission to Verbally Discuss Protected Health Information

Harbor Psychiatry and Mental Health knows that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk with about your medical care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our office, or by calling 949-887-7187.

What if I change my mind?

You can change or revoke (stop) this process at any time by writing to us at the address shown below, or by calling 949-887-7187.

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Where do I send the completed form or any changes?

Mail to: Harbor Psychiatry and Mental Health

4631 Teller Ave Suite 100
Newport Beach, CA 92660
Or Fax to
949-476-3080

Name of person to share information with

Relationship to patient

Signature of Patient

Date



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FINANCIAL RESPONSIBILITY

Harbor Psychiatry and Mental Health participates with most major health plans and will accept payment directly from them. As a courtesy to you, we will send claims **into** your primary, and secondary carriers, if necessary. However, it is important that you understand your insurance policy and benefits are an arrangement (contract) between you and your insurance company. You are personally responsible for all allowable fees as directed by your insurance company, as well as non-covered services that you have agreed to. These fees are usually categorized as a Copay, a Co-Ins (percentage), or a Deductible. Certain insurance plans will authorize a specific number of visits for a certain period of time. Please be sure that you are aware of these details, as you will be personally liable for any visits that fall outside of that scope and are denied by your plan. When in doubt, please verify this information with your insurance company. Our staff will make their best effort to verify insurance eligibility and benefits, but ultimately it is the patient's responsibility to know their policy and coverage. All patients that present without valid insurance information will be considered a Self-Pay Patient and will be required to pay at the time service is rendered, unless prior arrangements have been made.

I have read and understand Harbor Psychiatry & Mental Health's financial responsibility agreement.

Patient Printed Name

Patient Signature, if of legal age

Date

Parent/Guardian Printed Name

Parent/Guardian Signature



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MEDICATION APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your psychiatric care to Harbor Psychiatry & Mental Health. When you schedule an appointment we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation / No Show Policy below:

Effective **October 1, 2019**

- Any established patient who fails to show or cancels / reschedules an appointment and has not contacted our office with at least **24 hours notice** will be considered a No Show and charged a **\$50.00 fee**.
- Any established patient who fails to show or cancels / reschedules an appointment with no 24 hour notice a **second time** will be charged a **\$75.00 fee**.
- If a **third** No Show or cancellation / reschedule with no 24 hour notice should occur the patient may be **dismissed** from Harbor Psychiatry & Mental Health.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.
- Failure to adhere to a treatment plan may result in termination / dismissal of care from Harbor Psychiatry & Mental Health.

Cal-Optima Patients:

- Any established patient who fails to show or cancels / reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show.
- Any established patient who fails to show or cancels an appointment without a 24 hour notice a **second time can no longer make a scheduled appointment and can only be seen with a same day appointment or as a walk-in**. Please be aware that there is no guarantee that you will be seen on a walk-in appointment and there may be a long wait time. It's advised that you call the office the morning that you wish to be seen.
- Any established patient who fails to show to **3 appointments** including therapy and or same day appointments may be **dismissed** from Harbor Psychiatry & Mental Health.
- Failure to adhere to a **treatment** plan may result in termination / dismissal of care from Harbor Psychiatry & Mental Health.

I have read and understand the Medical Appointment Cancellation / No Show Policy and agree to its terms:

Signature of Patient/Representative

Date

Printed Name of Patient/ Representative



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HPMH PSYCHOTHERAPY NO-SHOW AND CANCELLATION POLICY

Please be aware that our providers block 40-60 minutes of their time when you schedule a therapy appointment. When a client **no-shows their** appointment, or cancels an appointment that goes unfilled, our provider is not compensated for that time that they have reserved for you. For this reason, we require that clients in therapy show a level of commitment and responsibility that allows for therapy to be successful, and also allows our practice to continue providing care. Remember that if our providers are not adequately compensated for their work they cannot be here to help our clients.

Effective October 1, 2019

1. Recurring therapy appointments cannot be scheduled beyond 6 weeks.
2. If a client fails to **show up to an** initial psychotherapy appointment, they incur a \$75 no-show fee and will not be given another appointment until that no-show fee is paid.
3. In order to schedule recurring appointments, there will need to be a credit card on file and any no shows will be automatically charged to that card.
4. If a client cancels or reschedules 2 consecutive therapy appointments with 24 notice, the client can no longer schedule recurring appointments and all future recurring appointments will be automatically **canceled**. This is an indication that the client may no longer be committed to recurring therapy.
5. If a client no-show to 3 psychotherapy appointments, HPMH may terminate therapy services at the provider's discretion due to the **patient's** lack of commitment to treatment.
6. Failure to show to a same day therapy appointment is considered a no-show and a no-show fee applies

CalOptima Patients:

1. Recurring therapy appointments cannot be scheduled beyond 6 weeks.
2. If a patient fails to show an initial psychotherapy appointment they will not be given another appointment.
3. The first no-show is waived.
4. On the 2nd no-show all future recurring appointments are **canceled**, and the client can no longer schedule recurring appointments and can only schedule therapy one appointment at a time.
5. If a patient no-show to 3 psychotherapy appointments, HPMH may terminate therapy services at the provider's discretion due to the patient's lack of commitment to treatment.
6. If a client cancels or reschedules 2 consecutive therapy appointments with 24 notice, the client can no longer schedule recurring appointments and future recurring appointments will be automatically **canceled**. This is an indication that the client may no longer be committed to recurring therapy.
7. Failure to show to a same day therapy appointment is considered a no-show.

Signature of Patient/Representative

Date

Printed Name of Patient/ Representative



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Psychological Testing No-Show Policy / Spravato Treatment No-Show Policy

Psychological Testing

There is a great deal of staff time and effort that goes into obtaining insurance authorization for psychological testing. Additionally we must block out 2 hours from the **provider's** schedule for the patient. For these reasons we require a 72 hour notice for all psychological testing appointment cancellations. Failure to do so will result in a \$150 No Show fee.

Additionally for patients with CalOptima, failure to provide 72 hour notice for these types of appointments will also result in not being able to make appointments in advance and therefore needing to make appointments "Same-Day". There is no guarantee there will be open appointment availability for same day testing appointments.

Spravato Treatment

We must reserve a treatment room for 2.5 hours, and set aside provider time for each patient that is undergoing Spravo treatment. There is also time that goes into obtaining insurance authorization, scheduling and delivery of the medication. For these reasons, we require 72 hour notice for all appointment cancellations. Failure to do so will result in a \$150 No Show fee. For patients with CalOptima, failure to provide 72 hour notice for appointment cancellations will result in being required to make appointments only on the day they would like to be seen. There is no guarantee that there will be open appointment availability **for the day** of appointments.

Signature

Patient or Person authorized to Consent

Date



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NABLA Consent

Some state and federal laws require patient consent to use ambient scribing solutions.

HPMH uses a HIPAA compliant software tool called Nabla to make it easier to write down medical notes. It helps your provider spend more time focused on your care, and less time on the computer. This tool will listen to the visit and convert it into a summary, which your provider will review and edit for accuracy. The tool will have access to the audio of the conversation during your visit, but it will not be saved and will not be used further by the tool. Your medical information will stay private and only shared with those you allow.

By signing below, you consent to the use of this tool during our visit and future visits

X _____

Patient Signature

X _____

Patient Name



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Patient Agreement for Controlled Substances – Stimulants

1. If you are receiving a stimulant for any reason including attention-deficit hyperactivity disorder (ADHD), we do not allow more than minimal alcohol and cannabis use. You must not use any other substances of abuse (non-prescribed opioids; cocaine; methamphetamines; hallucinogens; sedatives/hypnotics).

a) Minimal cannabis use is defined by using cannabis in any form once per week. Frequent use is defined by using multiple times 2 per week. Minimal alcohol use is defined as drinking < 1 drink per day.

b) Decreased concentration is a well-known side effect of frequent marijuana and alcohol abuse. If you use marijuana or alcohol frequently, it is impossible to tell if your decreased concentration is from marijuana or ADHD. Stimulant medications are highly controlled substances and only approved for the treatment of ADHD. Therefore, we will not prescribe a stimulant if there is a chance of decreased concentration from other substances of abuse and not from ADHD.

2. All patients being prescribed ongoing stimulant medications for ADHD must have a diagnosis of ADD/ADHD via formal psychological testing. An acceptable psychological test must include CPT/computerized/TOVA performed by a psychologist. This test can be from HPMH or an outside clinic. A copy of the psychological test results must be obtained and uploaded into the chart. If the psychological test results cannot be obtained, the patient must be re-tested in order to continue prescribing stimulants or approved by a medical director.

3. A negative urine drug screen (UDS) may be required before starting stimulant Treatment.

- UDS may be required periodically and randomly during stimulant treatment. Your treatment provider will also periodically conduct substance use assessments with you.

1. If a UDS is requested, you have 7-10 days to complete it from the time you are informed.
2. If you do not comply with the request, your treatment provider may hold stimulant treatment.
3. If the repeat UDS is positive and/or a substance use disorder is suspected, your clinician can pause

or end stimulant treatment at any time.

4. A controlled medication prescription can be paused or stopped at any time by your treatment provider if there is suspicion for substance abuse or diversion.
5. This agreement does not encompass all controlled medication prescriptions. There is a separate agreement document for ketamine; benzodiazepines & opioids; and buprenorphine.

Please print name

Patient/Parent/Guardian Signature

Date



HARBOR PSYCHIATRY
& MENTAL HEALTH

4631 Teller Ave #100 Newport Beach, CA 92660 Phone: 949-887-7187 Fax 949-476-3080

Dear patient,

Please be advised that HMPH will no longer refill **controlled substances** without the patient being seen by a provider. Providers are required to follow strict guidelines set forth by the DEA and medical license governing agencies when prescribing schedule I-IV controlled substances. Some of these medications, including stimulants, will not be accepted by the pharmacy as a refill and will require a new prescription. Patients also must be closely monitored when being prescribed controlled substances. Additionally, providers are mandated to review a CURES report prior to prescribing a controlled substance. A CURES report identifies any other controlled substance that a patient has filled at any pharmacy. For primarily these reasons, HPMH will no longer fulfill telephone or pharmacy refill requests for a controlled substance including benzodiazepines (xanax, ativan, klonopin, ambien, lunesta, restoril etc) and stimulants (adderall, ritalin, concerta, vyvanse, mydayis, etc). Therefore, it is the responsibility of the patient to attend their appointments, and to appropriately schedule their follow-up appointments in advance, before they run out of their medication. It is recommended that you schedule a follow-up appointment on the same day as your appointment while your provider has available appointments.

I understand that if I am out of a medication that is a controlled substance, I will not be provided a refill without being seen by a provider.

Please type your name to sign below

Print Name: _____

Date: _____

Signature: _____

☐ I am the parent/guardian of this patient



HARBOR PSYCHIATRY & MENTAL HEALTH

4631 Teller Ave Suite 100 Newport Beach, CA
Phone: 949-887-7187 Fax 949-476-3080

Patient Name: _____ Date of Birth: _____

What kind of services are you seeking today?

- ☐ Psychiatry
- ☐ Psychology

Part 1: Exclusionary Criteria for both Medication Management and Psychotherapy

- ☐ History of Fire setting
- ☐ Perpetrator of Sexual Abuse to a minor
- ☐ Suicidal at time Intake
- ☐ Homicidal at time of Intake
- ☐ Step-down from a Higher Level of Care (Residential, Inpatient, PHP or IOP) in the past 6 months without a discharge summary that recommends Outpatient.
- ☐ <18 yrs old with inpatient hospitalization within past 6 months
- ☐ Active Eating Disorder with BMI < 17.5
- ☐ Purging >3 times per week
- ☐ Fluid restriction for 24+ hours
- ☐ Food avoidance for 48+ hours
- ☐ Food bingeing episodes >4 times per week
- ☐ Active Auditory Command hallucinations
- ☐ State hospital or forensic discharge
- ☐ No verifiable address (cannot admit P.O. Box)
- ☐ History or threat of school / workplace violence
- ☐ Custody Evaluations / Letters or other matters involving forensic psychiatry
- ☐ SSI paperwork, JV220a paperwork
- ☐ Active detox without medical management
- ☐ None of the above

Part 2: Exclusions to Medication Management

- ☐ Seeking an evaluation for Autism Spectrum Disorder
- ☐ None of the above

Part 3: Exclusions to Psychotherapy

- ☐ Autism Spectrum Disorder Level 2 or Level 3
- ☐ Intellectual Disability with IQ <70 with or without other neurodevelopmental physical conditions
- ☐ Expressive / Receptive Language impairment
- ☐ None of the above

Have you tried at least two different antidepressants without success, and are you interested in learning more about safe, effective, non-drug treatment for depression known as Transcranial Magnetic Stimulation (TMS)?

- ☐ Yes, I am interested.
- ☐ No, I am not interested.
- ☐ None of the above



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Mental Health Intake

Name _____ Date _____

Date of Birth _____ Primary Care Physician _____

Current Therapist/ Counselor _____ Phone _____

What are the problem(s) for which you are seeking help? (Chief Complaint)

1. _____
2. _____
3. _____

What are your treatment goals?

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

- | | | |
|--|--|---|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety attacks |
| <input type="checkbox"/> Sleep pattern disturbance | <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Hallucination |
| <input type="checkbox"/> Concentration/forgetfulness | <input type="checkbox"/> Decrease need for sleep | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Crying spells | <input type="checkbox"/> _____ |

Past Medical History:

Allergies _____ Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date
-----------------	--------------------	----------------------

Current over-the-counter medications or supplements: _____

Current medical problems: _____

Past medical problems, non psychiatric hospitalization, or surgeries: _____



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For Women Only: Are you currently pregnant or do you think you might be pregnant? () Yes () No. Are you planning to get pregnant in the near future? () Yes () No

Are you breastfeeding? _____

For All Patients: Do you currently drive? () Yes () No

Personal Medical History:

Thyroid Disease -----	Y__N__	Diabetes -----	Y__N__
Kidney Disease -----	Y__N__	Bulimia/ Eating Disorders-----	Y__N__
Renal Impairment-----	Y__N__	Mania-----	Y__N__
Urinary Retention-----	Y__N__	Cardiomyopathy-----	Y__N__
Prostatic Hypertrophy-----	Y__N__	Congestive Heart Disease-----	Y__N__
Liver Disease -----	Y__N__	Electrolyte Abnormalities-----	Y__N__
Anemia-----	Y__N__	Arteriovenous Malformation-----	Y__N__
Porphyria-----	Y__N__	Epilepsy or seizures -----	Y__N__
Abnormal White Blood Count-----	Y__N__	Chronic Pain -----	Y__N__
Asthma-----	Y__N__	Head trauma -----	Y__N__
Pulmonary Impairment-----	Y__N__	Seizures-----	Y__N__
Sleep Apnea-----	Y__N__	Glaucoma-----	Y__N__
Stomach or intestinal problems----	Y__N__	Tics-----	Y__N__
Cancer (type) -----	Y__N__	Parkinson's Disease-----	Y__N__
Fibromyalgia-----	Y__N__	Confusion or difficulty w/memory- Y__N__	
Heart Disease-----	Y__N__	Head injury/ loss of consciousness- Y__N__	
High Cholesterol -----	Y__N__	Blurry or Double-vision-----	Y__N__
High Blood Pressure-----	Y__N__	Low Blood Pressure-----	Y__N__
Psychosis-----	Y__N__	Arrhythmia-----	Y__N__
Abnormal EKG-----	Y__N__	Cardiac structural abnormalities---	Y__N__
Cardiac structural abnormalities---	Y__N__		
Visual, Sensory/Auditory Hallucinations	Y__N__		

Past Psychiatric History:

Outpatient Treatment () Yes () No -- If yes, please describe when, by whom, and nature of treatment. Reason
Dates Treated By Whom

Psychiatric Hospitalization () Yes () No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where



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Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, Response and Side Effects (if you can't remember all the details, just write in what you do remember).

Antidepressants

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Silenor (doxepin) _____
Anafranil (clomipramine) _____
Elavil (amitriptyline) _____
Brintellix (vortioxetine) _____
Viibryd (vilazodone) _____
Pristiq (desvenlafaxine) _____
Fetzima (levomilnacipran) _____

Mood Stabilizers

Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Tegretol (carbamazepine) _____
Topamax (topiramate) _____
Neurontin (gabapentin) _____
Zyprexa (olanzapine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____

Antipsychotics/Mood Stabilizers

Dates

Dosage

Response/Side-Effects

Seroquel (quetiapine) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Latuda (lurasidone) _____
Risperdal (risperidone) _____

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____

ADHD Medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____



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Vyvanse _____

Antianxiety Medications

Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clonazepam) _____

Buspar (buspirone) _____

Gabapentin _____

Alcohol & Opioid Dependency

Suboxone, Subutex (buprenorphine naloxone) _____

Methadone, Revia (naltrexone) _____

Vivitrol (naltrexone) _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder () Yes () No

Schizophrenia () Yes () No

Depression () Yes () No

Post-Traumatic Stress () Yes () No

Anxiety Anger () Yes () No

Alcohol Abuse () Yes () No

Suicide () Yes () No

Other Substance Abuse () Yes () No

Violence () Yes () No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? () Yes () No

If yes, who was treated, what medications did they take, and how effective was the treatment?

Family Medical History:

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? () Yes () No

If yes, for which substances? _____

If yes, where were you treated and when? _____

On average, how many days per week do you drink any alcohol? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you should cut down on your drinking or drug use? () Yes () No

Have people annoyed you by criticizing your drinking or drug use? () Yes () No

Have you ever felt bad or guilty about your drinking or drug use? () Yes () No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

() Yes () No

Do you think you may have a problem with alcohol or drug use? () Yes () No

Have you used any illicit drugs in the past 3 months? () Yes () No

If yes, which ones? _____

Have you ever abused prescription medication? () Yes () No

If yes, which ones and for how long? _____



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Check if you have ever tried the following:

Tobacco History:

Have you ever smoked cigarettes? () Yes () No

Currently? () Yes () No How many packs per day on average? _____ How many years? _____

In the past? () Yes () No. How many years have you smoked? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? () Yes () No In the past? () Yes () No

What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? () Yes () No

Where did you grow up? _____

List your siblings and their ages: _____

Did you parents' divorce? () Yes () No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____ Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: () Working () Student () Unemployed () Disabled () Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Relationship History and Current Family:

Are you currently: () Married () Partnered () Divorced () Single () Widowed

If not married, are you currently in a relationship? () Yes () No If yes, how long? _____

Have you had any prior marriages? () Yes () No.

Do you have children? () Yes () No If yes, list ages and gender: _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? () Yes () No.

Legal History:

Have you ever been arrested? _____ Do you have any pending legal problems? _____

Do you have access to guns? If yes, please explain _____

Housing:

List everyone who currently lives with you: _____

SUICIDE RISK ASSESSMENT :

Have you ever had feelings or thoughts that you didn't want to live? () Yes () No.

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? () Yes () No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

HPMH Symptom Inventory Questionnaire (HSIQ-5)

Rate the following on a score of 1-10, 1 being absent and 10 being present nearly at all times and 5 being present occasionally.

Block A:

Fatigue:

Decreased Interest:

Problems with Concentration:

Lack of Motivation:

Diminished Enjoyment of Activities:

Difficulty Starting Tasks:

Difficulty Completing Tasks:

Looking Forward to Future Events:

Not Caring About Things:

Total:

Block B:

Irritability:

Anger:

Sadness:

Crying Spells:

Anxiety:

Repetitive or Obsessive Thinking:

Mood Reactivity (how much does your mood change in response to stressors or triggers?):

Sensitivity to Criticism:

Feeling very Emotional:

Total:

Block C:

Difficulty Falling Asleep:

Difficulty Staying Asleep:

Early Morning Awakening:

Nightmares:

Frequent Nighttime Awakening:

Difficulty Falling Back to Sleep after Awakening:

Often sleeping more than 9 hours :

Often Sleeping less than 6 hours:

Total:

Block D:

Persisting for at least 4 consecutive days and not in the context of drug use :

Decreased sleep without feeling tired:

Marked increase in goal-directed activities or energy:

Increased irritability, anger or annoyance in excess of what is appropriate for the trigger:

Rapid flow of ideas which may be observable in rapid or increased speech:

Increased self-esteem and appraisal of his/her worth, contacts, power or knowledge (delusions) as compared with usual level:

Increased spending, increased libido, increase in risk or impulsive (non well thought out) behaviors:

Elevated or optimistic mood out of proportion to the situation :

Increased attention or interest in others:

Total:

10: strong history present, 0: no history presents

Block D:

Thoughts of suicide:

Self-harm Behaviors:

Guilt:

Negative Self-Evaluation:

Hopelessness:

Helplessness:

Block E:

History of suicidal behaviors:

History of aggressive behaviors:

History of impulsive behaviors:

PERSONALITY ASSESSMENT INVENTORY

Name		
Value	QUESTION	POSSIBLE VALUES
	My mood can shift quite suddenly.	0 = False, Not at all true 1 = Slightly true 2 = Mainly true 3 = Very true
	My attitude about myself changes a lot.	
	I can act recklessly at times.	
	My relationships have been stormy.	
	My moods get quite intense.	
	Sometimes I feel terribly empty inside.	
	I can cut off close relationships abruptly.	
	I want to let certain people know how much they've hurt me.	
	My emotions can get uncontrollable.	
	I worry a lot about other people leaving me.	
	What I value and believe in often changes.	
	People once close to me have let me down.	
	I have little control over my anger.	
	I often wonder what I should do with my life.	
	I have a hard time staying at a job for a long time.	
	I can feel very lonely at times.	
	I have a hard time controlling strong or intense emotions.	
	I sometimes do things so impulsively that I get into trouble.	
	I can do things that are harmful to myself.	
	I can get extremely disappointed in others.	
	I can't handle separation from those close to me very well.	
	I've made some real mistakes in the people I've picked as friends.	

	I have sought ways to quickly end my emotional pain.	0 = False, Not at all true 1 = Slightly true 2 = Mainly true 3 = Very true
	When I'm upset, I might do something to hurt myself.	
	I've had times when I was so mad I couldn't do enough to express all my anger.	
	I get bored very easily.	
	My close friendships often end.	
	I can act very impulsive at times.	
	My relationships with loved ones can be chaotic.	
	I spend money too easily.	
	I can't tolerate negative emotions.	
	I often feel betrayed by others.	
	I can get very sensitive to criticism.	
	I can be self-punishing a times.	
	I've experienced paranoid thoughts when feeling stressed.	
	Negative emotions last longer than I would expect them to.	
	I can get triggered easily.	
	I can feel out of control.	
	I often experience intense emotions.	
Total Score	39 items	Average



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Adult Self-Report ADD/ADHD Screener

Not at all or never: 0

Just a little, once in a while: 1

Pretty Much, often: 2

Very much, very frequently: 3

- 1. I interrupt others when talking.**
- 2. I lose things necessary for tasks or activities.**
- 3. I'm disorganized.**
- 4. I can't keep my mind on something unless it's really interesting.**
- 5. I have trouble listening to what other people are saying.**
- 6. I have trouble waiting in line or taking turns with others.**
- 7. I blurt out things.**
- 8. I don't finish things I start.**
- 9. I say things without thinking.**
- 10. I have trouble keeping my attention focused when I'm working.**
- 11. I dislike quiet introspective activities.**
- 12. I feel restless inside even when I'm sitting still.**
- 13. I lose things that I need.**
- 14. I seek out fast-paced exciting activities.**
- 15. I forget to remember things.**



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- 16. I make comments/remarks that I wish I could take back.**
- 17. I misjudge how long it takes to do something or go somewhere.**
- 18. It's hard for me to keep track of several things at once.**
- 19. I am distracted when things are going on around me.**
- 20. I can't sit still for very long.**
- 21. I am absent minded in daily activities**



Rapid Mood Screener (RMS)

Answer the following questionnaire about your medical history to assist in an important conversation about your mood

1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?

☐ Yes

☐ No

2. Did you have problems with depression before the age of 18?

☐ Yes

☐ No

3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?

☐ Yes

☐ No

4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?

☐ Yes

☐ No

5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?

☐ Yes

☐ No

6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?

☐ Yes

☐ No

Total "Yes" Responses:



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GAD-7 (General Anxiety Disorder-7)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More than half the days	Nearly Every Day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column Totals: _____ + _____ + _____ + _____

Add Totals Together: _____



HARBOR PSYCHIATRY
& MENTAL HEALTH

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Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More than half the days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way	0	1	2	3

Column Totals: _____ + _____ + _____ + _____

Add Totals Together: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult



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PTSD Checklist for DSM-5 (PCL-5)

Patient Name: _____ Date: _____

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then select one of the options to the right to indicate how much you have been bothered by that problem in the past month.

Not at All A little bit Moderately Quite a bit Extremely

1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminds you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4

12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being superalert or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Column Totals: _____ + _____ + _____ + _____ + _____

Add Totals Together: _____