Carl Fleisher, M.D.
Child, Adolescent, and Adult Psychiatry
204 S. Beverly Drive, Suite 107, Beverly Hills, CA 90212
Tel: (310) 596-1555 Fax: (888) 317-0391
Email: drcarl@drcarlfleisher.com www.drcarlfleisher.com

Date ______/______/______

NEW PATIENT REGISTRATION

1. BACKGROUND INFORMATION

PATIENT INFORMATION

Name ________________________________ DOB ____/____/____ Age _____
Gender ☐ Female ☐ Male ☐ Other ________________
Pronouns ☐ She/her/hers ☐ He/him/his ☐ They/Them/Theirs ☐ Other
Address ____
City ____________________________ State: _______ Zip ______________
Email ____ *see Email Disclosure below

	Phone Number	Okay to call?	Okay to leave a message?
Cell		Y N	Y N
Home		Y N	Y N
Work		Y N	Y N

Best number to contact: ☐ Cell ☐ Home ☐ Work

Employer ________________________ Occupation ____________________________
Time at current job: ______________
If not presently employed: ☐ Looking for work ☐ Full time child care ☐ Retired
Number of previous jobs: ______

EMERGENCY CONTACT INFORMATION

Name ________________________________ Telephone ________________
Relationship to patient ___________________ Email _____________________

PRIMARY CONCERN

Main reason for seeking help now: ____
____
____

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How long have you had these problems or symptoms? ___________________________________

____

How often do they occur? ____

____

What are your goals for treatment? ____

____

____

What other treatments have you tried? ____

____

____

MEDICAL INFORMATION

Primary Care Physician ____________________________ Telephone __________________
Last Seen _______/______/______
Insurance (for authorization of certain prescription medications)

1. Carrier: ___________________________
2. ID: ___________________________

Are you currently taking any medications (both prescribed and over-the-counter or herbal)?
☐ Yes (describe below) ☐ No

Medication	Dose	Times per day	Taking since?

Do you have any allergies to any medication? ☐ Yes ☐ No
If yes, please list with associated reaction: ____

Do you have any serious or chronic medical conditions (and year that the condition began)?
☐ Diabetes: _________
☐ High cholesterol: __________
☐ High blood pressure: _____________
☐ Heart attack: _____________
☐ Stroke: ___________

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☐ Cancer: ___________
☐ Auto-immune disease: _____________
☐ Overweight/obesity: ______________
☐ Other: ________________________________

Please list all surgeries (for example, wisdom teeth, joint surgery, cosmetic):

Year	Surgery	Resolved/Healed?

Have you had:
☐ A serious accident or injury
☐ concussion, or a head injury leading to loss of consciousness
☐ seizures or epilepsy
If yes, please provide date(s) and details: ____
____

EDUCATIONAL INFORMATION

School completed: ☐ High school ☐ Some college ☐ College ☐ Graduate/Doctorate
GPA or typical grades: ______________________
Repeated/held back ☐ No ☐ Yes Skipped ☐ No ☐ Yes
Suspended ☐ No ☐ Yes Expelled ☐ No ☐ Yes

SOCIAL INFORMATION

Hobbies and fun activities: ____
Social media accounts: ☐ Facebook ☐ Snapchat ☐ Instagram ☐ Other: ___________
Marital status: ☐ Married/Partnered ☐ Single ☐ Widowed
☐ Divorced ☐ Separated
If married/partnered: Living with partner ☐ No ☐ Yes Years together: ____
If unmarried/partnered: Current relationship: ☐ Man ☐ Woman Duration: _____
Past romantic relationships: ☐ Men ☐ Women Longest: ______
Spiritual/religious affiliation:
☐ Christian/Catholic ☐ Muslim ☐ Jewish ☐ Hindu ☐ Agnostic
☐ Atheist ☐ Buddhist ☐ Other: ___________________

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PSYCHIATRIC TREATMENT

Please list any previous psychiatric treatment:

____
____
____

Please list any psychiatric medication that you have tried in the past:

Medication	Dose	For treatment of	Total length of treatment	Length of treatment at highest dose	Reason stopped

Pharmacy Name ______________________ Phone Number ____________

RISK BEHAVIOR

There is a gun at home: ☐ No ☐ Yes
I use seat belts: ☐ Always ☐ Other: __________
Have you ever been detained or arrested? ☐ No ☐ Yes
Do you use drugs or drink alcohol? ☐ No ☐ Yes
If yes, how many times have you used the following substances:
Marijuana: _______per day ______per week ____per month ____per year
Alcohol: _______per day ______per week ____per month ____per year
Other: _______per day ______per week ____per month ____per year
Comment: ____

Previous alcohol/drug treatment programs (dates and locations) ________________
____
How long ago did you stop using (if applicable)? ________________
How many caffeinated beverages do you drink per day? (coffee, tea, energy drinks, etc.)
____

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FAMILY INFORMATION

Significant deaths, losses, or traumatic events in the family (include year): ____________________
____
____

Have any relatives struggled with or been treated for (if yes, please say whom and describe):

- ☐ Depression ____________________
- ☐ Anxiety ____________________
- ☐ ADHD/ADD ____________________
- ☐ Autism/Aspergers ____________________
- ☐ Tics ____________________
- ☐ OCD ____________________
- ☐ Addiction/alcoholism ____________________
- ☐ PTSD ____________________
- ☐ Schizophrenia ____________________
- ☐ Bipolar disorder ____________________
- ☐ Chronic pain ____________________
- ☐ Chronic fatigue syndrome ____________________
- ☐ Migraines ____________________
- ☐ Other brain/neurological disorder ____________________

Have any relatives committed suicide? ☐ Yes ☐ No

If yes: Year________ Relationship to you ________________

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2. MEDICAL REVIEW OF SYSTEMS

Name:___________________________ Date:__/__/_____

Check if you have the following:

GENERAL
___Fever
___Chills
___Sweats
___Fatigue/Weakness
___Loss of appetite
___Malaise
___Weight Loss
___Sleep Disorder

EYES
___Blurring
___Double Vision
___Eye Irritation
___Eye Discharge
___Vision Loss
___Eye Pain
___Light Sensitivity

EARS, NOSE & THROAT
___Earache
___Ear Discharge
___Ringing in Ears
___Decreased Hearing
___Hoarseness
___Nosebleeds
___Sore Throat
___Nasal Congestion

CARDIOVASCULAR
___Chest Pain
___Bluish Color Lips/Nails
___Difficulty Breathing with Exertion
___Palpitations
___Leg swelling
___Fainting

RESPIRATORY
___Cough
___Cough with Exercise
___Difficulty Breathing at Rest
___Excessive Sputum
___Coughing up Blood
___Nighttime Cough/Wheeze
___Wheezing

GASTROINTESTINAL
___Nausea
___Vomiting
___Diarrhea
___Constipation
___Change in Bowel Habits ___Abdominal Pain
___Dark, Tarry Stools
___Bloody Stools
___Yellow Skin Color
___Gas/Bloating
___Indigestion/Heartburn
___Difficulty Swallowing

GENITOURINARY
___Vaginal Discharge
___Incontinence
___Daytime Urination
___Nighttime Urination
___Painful Urination
___Blood in Urine
___Urinary Frequency
___Abnormal Periods
___Painful Periods
___Abnormal Vaginal Bleeding
___Pelvic Pain
___Genital Sores

MUSCULOSKELETAL
___Back Pain
___Joint Pain
___Joint Swelling
___Muscle Cramps

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MUSCULOSKELETAL (cont.)
___Muscle Weakness
___Stiffness
___Arthritis
___Low Back Pain
___Restless Legs
___Leg Pain at Night
___Leg Pain with Exertion

DERMATOLOGIC
___Rash
___Itching
___Dryness
___Suspicious Lesions

NEUROLOGICAL
___Abnormal Walking
___Frequent Falls
___Frequent Headaches
___Increased Tone in Limbs
___Paralysis
___Numbness or Tingling
___Seizures
___Tremors
___Poor Balance
___Weakness of Limbs

ENDOCRINE
___Cold Intolerance
___Heat Intolerance
___Excessive Thirst
___Excessive Hunger
___Excessive Urination
___Unusual Weight Change

HEMATOLOGIC
___Abnormal Bruising
___Bleeding
___Enlarged Lymph Nodes

ALLERGIC
___Hives
___Allergic Rash
___Hay Fever
___Recurrent Infections

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3. DECLARATION OF PATIENTS' RIGHTS AND RESPONSIBILITIES

It is the policy of this Corporation that physicians will provide psychiatric treatment in an environment that preserves the rights of all individuals. These rights are listed below.

STATEMENT OF PATIENTS' RIGHTS

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your personal values and beliefs.
2. Receive information about your health status, course of treatment and prospects for recovery in terms you can understand. You have the right to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution.
3. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non- treatment and the risks involved in each.
4. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services.
5. Be advised if the physician proposes to engage in or perform experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
6. Reasonable responses to any reasonable requests made for service.
7. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely.
8. Confidential treatment of all communications and records pertaining to your care. Written permission shall be obtained before medical records are made available to anyone not directly concerned with your care, except as otherwise may be required or permitted by law.
9. Access information contained in your records within a reasonable time frame, except in certain circumstances specified by law.
10. Receive care in a safe setting, free from verbal or physical abuse or harassment. You have the right to access protective services including notifying government agencies of neglect or abuse.
11. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

12. Examine and receive an explanation of the physician's bill regardless of the source of payment.
13. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment of care.
14. File a complaint with the Medical Board of California. The complaint form can be downloaded at www.mbc.ca.gov. You may also call the Board's Consumer Protection Unit at (800) 633-2322 and request that a complaint form be mailed to you. The Board's address is: 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815.

STATEMENT OF PATIENT'S (AND PARENTS') RESPONSIBILITIES

1. The patient and/or parents are responsible for providing to the best of his/her knowledge, accurate and complete information about the present complaint, past illnesses, hospitalizations, medications and other matters relating to his/her health. The patient and/or parents are responsible for reporting unexpected changes in the patient's condition.
2. The patient and/or parents are responsible for asking questions when they do not understand what they have been told about their care or what they are expected to do.
3. The patient and/or parents are responsible for following the care, service or treatment plan developed. They should express any concerns they have about their ability to follow and comply with the proposed care plan or course of treatment. Every effort shall be made to adapt the plan to the patient's specific needs and limitations. When such adaptations to the treatment plan are not recommended, the patient and/or parents are responsible for understanding the consequences of the treatment alternatives and not following the proposed course.
4. The patient and/or parents are responsible for the outcomes if they do not follow the care, service or treatment plan.
5. The patient and/or parents are responsible for promptly meeting any financial obligation agreed to with this physician.
6. The patient and/or parents are responsible for understanding how to continue care after leaving the care of this physician including when and where to get further treatment and what the patient needs at home to help with treatment.
7. The patient and/or parents are responsible for keeping appointments. If the patient cannot keep an appointment, the patient and/or parents will notify the physician in advance, so that another patient can be scheduled at that time.

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By signing below I indicate that my rights and responsibilities were communicated to me.

___________________________	___________________________
Patient's Name	Name of Parent/Legal Guardian/Conservator
___________________________	___________________________
Patient's Signature	Signature of Parent/Legal Guardian/Conservator

Date: _____/_____/_____

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4. TERMS AND CONDITIONS OF TREATMENT

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
Comments/complaints: (800) 633-2322
www.mbc.ca.gov

THE LARGE PRINT

1. You can expect me to be prompt, professional, attentive, compassionate, effective, and efficient. I aim to be readily available by phone and email during the week; on weekends, I can be paged for urgent clinical matters. Emails and voicemails sent on the weekend may not be seen until the next business day. Text messages may not be seen/answered unless by prior agreement.
2. The best number of medications for anyone to take, especially children, is zero. Sometimes, however, that is not realistic. When I recommend medication, you can expect that I will aim to prescribe the lowest dose that is both safe and effective. I always endeavor to reduce or eliminate medications, when appropriate.
3. When I recommend therapy, I work together with you (or you and your child) to create a goal-directed, time-limited plan that builds the capacity to thrive without therapy.
4. I expect patients to be prompt and to say when things are not going well.
5. I expect refills of medication to be requested at least five (5) business days before pills run out.
6. Requests for forms/documents must be sent at least 1 week in advance.
7. Out of respect for other patients, if you must cancel or reschedule an appointment, please do so with at least 24 hours' notice. The full fee will be charged for missed appointments or late cancellations.
8. Please limit email use to the scheduling of appointments, or requests for prescription refills. See Email Disclosure below.

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THE FINE PRINT

ACCOMMODATIONS

Requests for work, school, or other accommodations raise complex questions about responsibility, capacity, managing distress and prognosis. Dr. Fleisher will support such requests if the accommodations are brief and necessary to help patients reach a treatment milestone. He may also support requests that promote healthy coping and lead to improvement in function. Unfortunately, some requests for accommodations serve short-term needs for reducing distress, while ultimately getting in the way of mature, healthy coping or other long-term goals. These requests are unlikely to be supported. For details on emotional support animals, please see the relevant section below.

APPOINTMENT TIMES

Appointments will start and end at their scheduled times, regardless of when the patient arrives, as it would be unfair to keep other patients waiting.

CANCELLATION POLICY

Should you need to cancel an appointment, please do so at least 24 hours in advance. Otherwise, you will be charged at the regular full rate for the canceled/missed session, unless this time slot can be otherwise filled with paid professional activity. Both telephone and email are acceptable ways to alert Dr. Fleisher of a cancellation.

CONFIDENTIALITY AND MANDATED REPORTING

Patient confidentiality is of upmost importance but it does have limits, under the law and the standard of care. Mental health professionals must not keep confidential instances of abuse or neglect; in fact, Dr. Fleisher is MANDATED by law to report even a suspicion of such behavior to state authorities. Judges also may order a mental health professional to disclose certain information. Furthermore, any imminent risk of harm to self or to others, or inability to care for oneself due to mental illness, in the professional opinion of a mental health provider, may be disclosed to appropriate agents.

CONTACT OUTSIDE OF APPOINTMENTS

Telephone messages should be left on Dr. Fleisher's voice mail at (310) 596-1555. He makes every effort to return all calls within 24 hours or the next business day. Dr. Fleisher is available on weekends by pager for emergencies and certain urgent clinical matters (see Emergencies, below). This does not include medication refills. Refill requests sent over the weekend may not be seen until the next business day. Concerns about physical safety (e.g., thoughts of suicide) must be communicated by live telephone conversation, not by email or voicemail. If Dr. Fleisher is not available for whatever reason, patients at risk of harm should go to the nearest emergency room. Dr. Fleisher is happy to return phone calls and emails to facilitate appointment scheduling and prescription refills. However, assessment and treatment planning must take place in person. If phone calls and emails for a particular patient concerning these latter issues become unusually frequent, please be aware that Dr. Fleisher may insist that the frequency of appointments be increased.

EMERGENCIES

In a life- or limb-threatening emergency, call 911. In the event of an urgent psychiatric matter that is not life- or limb-threatening, please page Dr. Fleisher by calling (310) 206-6766. If you have not been called back within 20-30 minutes, page again.

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EMAIL/TEXT MESSAGE DISCLOSURE

Email and text messaging are not a confidential means of communication. For this reason and because Dr. Fleisher cannot ensure that messages will be received or responded to in a timely fashion, it is neither safe nor appropriate to communicate by email/text any information that is private, sensitive, urgent, emergent, or otherwise time-sensitive. As above in the 'Large Print', email and text messages sent over the weekend may not be seen until the next business day.

EMOTIONAL SUPPORT ANIMALS

People should have, or be working towards, fulfilling and supportive relationships with other people. Dr. Fleisher will support having an emotional support animal only for those patients who are unable to maintain relationships with other people. In those cases, patients are expected to continue in treatment that will allow them to regain human relationships, at which point an emotional support animal need not be more than a beloved pet.

FEES AND FEE INCREASES

Dr. Fleisher appreciates the high cost of out-of-network care. He strives to maximize affordability, while also maintaining excellence. Due to the nature of inflation, please expect that fees will typically increase by 3-5% on January 1st every other year, in even-numbered years (e.g., 2020, 2022).

INITIAL ASSESSMENT

This assessment begins the process of determining the best treatment plan possible. It is specific to each patient. This assessment must be as comprehensive as possible; therefore, please bring and complete any forms requested. Please be sure to provide information about previous providers, past treatment, and medication trials. Please also bring outside evaluations, i.e., from school reports, psychological testing, etc. This is often helpful because these issues will be discussed as a part of the assessment. In most situations, more than one session is needed to complete an appropriate assessment. A comprehensive assessment is necessary to provide the best possible care regardless of the type of treatment offered (i.e., psychotherapy, psychiatric medications, or both). Additionally, you and Dr. Fleisher will mutually determine if he is the best clinician to provide your individualized care.

INSURANCE REIMBURSEMENT

Dr. Fleisher does not accept third-party payment at this time. As such, he is considered an "out of network" provider for most insurance plans. Therefore, you may wish to check with your carrier prior to scheduling an initial appointment. If your health benefits policy provides mental health coverage, you may be entitled to reimbursement from your insurance carrier for any professional services provided. Contact your insurance company directly to discuss this. Dr. Fleisher can provide you with a service invoice or receipt (i.e., "superbill") that you can submit to your insurance company. He will not bill your insurance company directly. Please note that if you pursue reimbursement, most insurance agreements require you to authorize Dr. Fleisher to divulge clinical information. Such information can include a diagnosis, historical information, treatment plans or summaries, and sometimes a copy of your medical record. In these cases, your/your child's clinical information will become a part of the insurance company files and can be used by them to consider future insurability.

LEGAL MATTERS

Dr. Fleisher will and must participate in testimony or deposition under subpoena from a judge. Dr. Fleisher will offer the minimum testimony necessary to answer the questions that are asked, to minimize

risks to doctor-patient privilege. Other requests for input into legal matters may be declined if such input is not in the best interests of the patient, especially if doing so would jeopardize doctor-patient privilege. Please note that Dr. Fleisher charges a separate fee in order to cover costs of preparation, document review and travel if an appearance is requested in court (for testimony) or in an attorney's office (for deposition). The fee is $750 per hour (subject to biennial fee increases) with a half-day (four-hour) minimum. Fees for legal matters must be paid in full on day of service. A late fee of $50 will be assessed for every week that payment is delayed.

MEDICATIONS

Psychiatric medications can be used in combination with psychotherapy to treat many conditions. It is important to find the best combination for each individual case; Dr. Fleisher is trained to administer both psychiatric medications and psychotherapy. In situations that warrant the use of medication(s), it is imperative for you/your child to understand the target symptoms and likely outcomes. Additionally, since all medications have the potential for side effects, Dr. Fleisher will always discuss with you (and your child) the risks, benefits, side effects, federal warnings, and alternative approaches; not using medication is always one alternative.

MEDICATION REFILLS

Dr. Fleisher is not able to refill medications without a recent evaluation; this ensures appropriate safety monitoring and provides an opportunity to assess whether each patient is progressing toward appropriate therapeutic goals. With that in mind, Dr. Fleisher will attempt to schedule your appointments such that an appointment is coming up prior to running out of medication. If you miss or abruptly cancel an appointment, you may be told that it is not clinically appropriate for your medication to be refilled until the next in-person meeting. Please request refills directly from Dr. Fleisher; pharmacies contact information for Dr. Fleisher may be out-of-date. Federal regulation prohibits refills for stimulant medication. Prescriptions for stimulant medications will not be given more frequently than once every three months.

PAYMENT

All outpatient visits must be paid for at the time of the visit. You are expected to pay at the end of each appointment. Dr. Fleisher accepts checks, cash, electronic fund transfer (EFT) and all major credit cards for his professional services. Credit card and EFT payments will be processed using mobile applications. Dr. Fleisher's acceptance of payment in this form does not express or imply any warranty against theft or other misuse of digital and financial information. Put simply, this form of payment should not be considered secure. Any overdue balance is due upon receipt. There is a returned check fee of $25. If your account is overdue for more than 60 days, Dr. Fleisher reserves the right to use legal means to secure payment. This includes charging a credit card on file as well as utilizing a collections agency or a small claims court. In such cases, only the minimum required information is provided to these agencies; this can include the patient's name, the nature of services provided, and amount due.

PROFESSIONAL RECORDS

Psychiatric records are protected by both legal and professional standards. Although you are entitled to review a copy of your records, these records can be misinterpreted given their sensitive nature. In rare cases, when providing you with full access to your records is deemed potentially damaging, Dr. Fleisher can review them together with you, and/or treatment summaries can be provided. Alternatively, they can be made available to the appropriate mental health professional of your

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choice. Please note that professional fees may be charged for any preparation time required to comply with such requests.

PSYCHOTHERAPY

Psychotherapy can be helpful to both individuals and families. Benefits could include significant stress reduction, improved relationships, resolution of specific problems, and improved self-insight. However, therapy is not guaranteed to work for everyone. Moreover, psychotherapy may require you/your child to explore unpleasant feelings in your life or yourself. Psychotherapy can, at times, lead to feelings of distress (i.e., guilt, anxiety, frustration, etc.). These unpleasant feelings are generally temporary but are extremely important to discuss when present. Thus, it is important to let your/your child's therapist know if you/your child experience such feelings or if you/your child find that the goals are not being met. Such issues can be addressed in session. Dr. Fleisher is also willing to find a therapist who is a better fit, if necessary.

TERMINATION OF TREATMENT

Psychotherapy produces a meaningful relationship. Stopping this abruptly raises the potential for current and/or future emotional harm. The end of psychotherapy serves as a model for how to cope with loss and grief; inadequate coping risks psychological distress at termination. An additional risk, especially with children, is that they end up feeling treatment with any provider is pointless.. Ideally, therapy ends when you/your child and Dr. Fleisher agree that treatment goals have been achieved. However, you/your child have the right to stop treatment at any time. If you/your child make this choice, Dr. Fleisher will request that you/your child attend at least one final 'termination' session to process the lost relationship and minimize harm or risk of harm to the patient.

My signature below shows that I have read, understand and accept all of these statements unless otherwise noted.

______________________________	______________________________
Printed name of patient	Signature of patient
Carl Fleisher, M.D.	______________________________
Printed name of clinician	Signature of clinician

Date ________/______/______

I, the clinician, have discussed the points above with the patient (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

☐ Copy accepted by patient ☐ Copy retained by office

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5. Health Information Release Form

Consent and Authorization to Use, Disclose and Receive Medical and Mental Health Information

I, ___________________________, hereby authorize Dr. Carl Fleisher to ☐ disclose ☐ and to receive information and records obtained in the course of diagnosis and treatment of ☐ myself or ☐ my child.

Information is to be disclosed to and/or from:

1. Name: ______________________ Phone: (   ) ______________
   Email: ______________________ Fax: (   ) ______________
2. Name: ______________________ Phone: (   ) ______________
   Email: ______________________ Fax: (   ) ______________

1. Method and purpose: Information and records may be shared by phone, fax, mail, or e-mail. The reason(s) for the disclosure is/are: to increase understanding of the medical and mental health history, diagnosis, and treatment, to coordinate care on an ongoing basis with other providers that are also treating me or my child, or to discuss treatment of myself or my child with people I have named as important sources of support.

2. Information to be released and/or accessed: Medical records may include information regarding diagnosis and treatment of drug or alcohol use, acquired immune deficiency syndrome (AIDS), or psychiatric disorders. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that federal regulations (42 CFR part 2) prohibit their making any further disclosures without my written consent or as otherwise permitted by said regulations. I specifically authorize the release or disclosure of the following designated protected health information (PHI) and/or records, if those exist:
   - Neuropsychological testing
   - History and Physical
   - Laboratory reports
   - Discharge summary
   - Alcohol/drug use
   - Genetic testing
   - Outpatient records
   - Progress note
   - Consultations/ evaluations

   (strike out inapplicable/disallowed PHI and/or records)

3. Substance use disorder information: By initialing below, I explicitly authorize, in accordance with 42 C.F.R. Part 2 the release/disclosure of alcohol, drug and substance use disorder information, if present in my protected health information, including, if present, diagnostic information, medications and dosages, lab tests, allergies, substance use history, and other data. I understand that if I do not authorize disclosure of alcohol, drug and substance use disorder information, much or all of my protected health information may not be released.

   ☐ (initial) I authorize disclosure of all my substance use disorder information

____
Initials (sign on Page 2)

4. Time period and right to revoke: This authorization is valid for 1 year, or the following specific period: ___________ I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by Dr. Fleisher to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

5. Signature authorization: I have read this form and agree to the uses and disclosures of information as described. I understand that I have the right to refuse consent and signing of this authorization and that Dr. Fleisher shall not condition my treatment or the treatment of those under my care upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy law (e.g., HIPAA), although applicable state laws may protect such information. I understand that I may copy or inspect any information to be used or disclosed under this authorization.

Signature: ________________________________ Date: ________/______/_______

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6. PATIENT-PROVIDER E-MAIL COMMUNICATION FORM

I hereby grant permission to Carl Fleisher, M.D. (the Provider), a representative of Carl Fleisher, M.D., Inc., to use electronic mail (e-mail) to communicate to me and/or my child. Said e-mail may contain clinical or billing information pertaining to health care services that I, or my child, have received or will receive. I acknowledge and understand that e-mail communication contains personal and private medical information that may include, but is not limited to, my name, address, date of birth, types and dates of health care services received, medication, insurance coverage information, and/or test results. I understand that, although the Provider may attempt to protect the privacy of the contents of e-mail sent to me and will take reasonable measures to protect my privacy, the e-mail messages sent to me are not encrypted and travel over the Internet. Even encrypted e-mail messages are not definitively protected. As a result, there is always a risk that the e-mail will be intercepted and read by unauthorized third parties. In allowing the Provider to send me e-mail, or by sending e-mail to the Provider, I acknowledge and assume this risk.

I also acknowledge and understand the following as it relates to this e-mail communication:

1. E-mail is not appropriate for conveying information relating to emergency medical matters.
2. Security of e-mail communications sent from or stored on my computer are my responsibility, not the Provider's.
3. My decision to allow the Provider to communicate with me by e-mail is voluntary, and treatment is not conditioned upon my election to do so.
4. The Provider or I may stop e-mail communication at any time for any reason.
5. I agree to notify the Provider when my e-mail address changes.
6. I will not hold the Provider responsible for damages resulting from the use of e-mail or from the failure of Provider's information systems used to facilitate the e-mail communication, including unplanned or unknown failure of security systems belonging to e-mail service providers, internet service providers, or other technology companies.

The Provider may communicate with me via e-mail using the designated account listed below:

Name (Print): ______________________________

My E-mail Address: ____

Patient Signature: ______________________________ Date: ___/___/______

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7. Acknowledgement of Receipt of Privacy Practices

The Notice of Privacy Practices on the following page is provided for your information.

I hereby acknowledge that I have been given a copy of the Notice of Privacy Practices.
I have had an opportunity to read and review this document. I have had an opportunity to ask any questions I may have related to privacy practices.

______________________________	______________________________
Printed name of patient	Signature of patient

Carl Fleisher, M.D.	______________________________
Printed name of clinician	Signature of clinician

Date ________/______/______

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8. Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- We never market, sell, trade, or otherwise disclose your information to third parties except as described in this notice.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights using the contact information on pg. 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases below, we never share your information unless you give us written permission:

- Most sharing of psychotherapy notes
- Substance use disorder treatment

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Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

1) Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

2) Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

3) Bill for our services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

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Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Terms for this Notice

- Effective November 1, 2016
- Questions or concerns: contact Dr. Carl Fleisher at drcarl@drcarlfleisher.com or (310) 596-1555