Corey S. Gonzales, Ph.D.
Licensed Clinical Psychologist
5001 East Commerce Center Drive, Suite 255
Bakersfield, CA 93309
(661) 323-2108

Patient Registration Form

(Please Print)

Date_____ Patient_____
Sex_____ Age_____ Birth Date_____
Complete Address_____
City_____ State_____ Zip_____
Mailing Address_____
City_____ State_____ Zip_____
Home Phone(___)_____ Cell Phone(___)_____
Social Security_____Drivers License_____
Years of Education_____Full Time Student: Yes No
Employer_____ Occupation_____
Employer Address_____
Work Phone(___)_____

If Patient Is A Minor - Parents Need To Complete "Parent/Minor Consent Form"

Marital Status: Single_____ Married_____Widowed____ Divorced_____
Name of Spouse_____Age_____Birth Date_____
Spouse's Social Security_____Spouse's Years of Education _____
Spouse's Employer_____ Work Phone_____
Spouse's Occupation_____
Person To Notify In Case Of Emergency_____
Phone_____
Who May We Thank For Referring You To Us?_____
Name of Your Family/Primary Physician_____
Address_____ Phone_____
Please List All Doctors You Are Currently Seeing_____
_____
Primary Complaint_____

Financial Responsible Party_____Relationship_____

If Someone Other Than Patient Is Financially Sponsoring Treatment, Please Complete "Financially Responsible Form"

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Dr. Gonzales Requires Consent From Both Biological Parents
If Patient Is A Minor (Under 18 Years Of Age)

Parent/Minor Consent Form

Father's Information/Consent For Dr. Gonzales To See Child

Name_____Age_____Birth Date_____
Social Security _____Drivers License_____
Complete Address_____
City_____State_____Zip_____
Mailing Address_____
City_____State_____Zip_____
Home Phone (___)_____Cell Phone (___)_____
Years of Education_____Full Time Student: Yes No
Employer_____ Occupation_____
Employer Address_____Phone(___)_____

Signature of Father Giving Consent _____

Mother's Information/Consent For Dr. Gonzales To See Child

Name_____Age_____Birth Date_____
Social Security_____Drivers License_____
Complete Address_____
City_____State_____Zip_____
Mailing Address_____
City_____State_____Zip_____
Home Phone (___)_____Cell Phone (___)_____
Years of Education_____Full Time Student: Yes No
Employer_____ Occupation_____
Employer Address_____Phone(___)_____

Signature of Mother Giving Consent_____

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Financially Responsible Party
(If Other Than Patient)

Name_____Age_____Birth Date_____
Social Security_____ Drivers License_____
Complete Address_____
City_____ State_____ Zip_____
Mailing Address_____
City_____ State_____ Zip_____
Home Phone (___)_____ Cell Phone (___)_____
Years of Education_____ Full Time Student: Yes No
Employer_____Occupation_____
Employer Address_____ Phone(___)_____

I _____acknowledge that I will be financially sponsoring_____ for mental health treatment. I acknowledge that I will be responsible for sending payment prior to the appointment, if I will not be attending session. I acknowledge that I will be financially responsible if _____ does not show up for an appointment or cancels less than 24 hours. I acknowledge that getting behind on payments will make myself eligible for collections.

Signature _____Date _____

Personal History Questionnaire

Name_____
Date_____

Are you seeking treatment for symptoms of:

_____Depression
_____Anxiety
_____Panic
_____Phobia
_____Eating disorder
_____Hallucinations
_____Marital or Family Conflict
_____Job Stress
_____Manic/Depressive or Bipolar
_____Substance Abuse or Alcoholism
_____Behavior problem
_____Learning difficulty
_____Other

Please indicate if you have any of the following symptoms:

_____Trouble concentrating
_____Insomnia or restless sleep
_____Withdrawn from friends
_____Decreased ability to feel pleasure
_____Recurrent sadness
_____Irritability
_____Thoughts of death or suicide
_____Fatigue or markedly decreased energy
_____Hypersensitivity to rejection
_____Mood variation with menstrual cycle
_____Recent weight change
_____Racing thoughts
_____Grandiose ideas
_____Decreased need for sleep
_____Excessive spending
_____Sexual impulsiveness
_____Violent outbursts
_____Seasonal mood variation

Have you ever had a problem with:

_____Alcohol
_____Cocaine
_____Crank
_____LSD
_____Marijuana
_____Downers
_____Pain killers
_____Heroin
_____PCP
_____Other Substances

Please identify any current sources of stress in your life:

_____Marriage, relationship or significant other
_____Seasonal mood variation
_____Employment
_____Finances
_____Medical problems
_____Legal problems
_____Child rearing
_____Parents
_____School
_____Other, specify

Have you ever been arrested for:

_____DUI
_____Any Felony

Please indicate any prior psychiatric inpatient/outpatient treatment with dates:

_____
_____
_____

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Consent For Treatment

In signing this form, I give permission for Dr. Corey S. Gonzales, to provide psychological evaluation and treatment for me and/or my minor child:

Confidentiality

According to California law, communication between a patient and psychologist is privileged and confidential. This means that you cannot be identified by name nor can the details of your treatment be shared with others without your written permission. There are, however, some situations in which California law requires that confidentiality must be waived:

a. When someone is in danger of hurting him/herself or others, the Psychologist must take steps to protect the patient or others.

b. When there is "reasonable suspicion" that a minor has been physically or sexually abused, grossly neglected or seriously endangered, the Psychologist must notify designated authorities.

c. When an elder or disabled citizen has been abused, a report must be made.

d. If a court of law subpoenas your records, a judge can order a Psychologist to produce them or testify about them.

However, keep in mind that I am trying to do whatever is in your best interest at all times. What you tell me in private, I may want to discuss in the presence of other family members. In telling me things, you will have to trust in my professional judgment to act in the best interests of you and your family.

If you are seeing a psychiatrist or a family physician for psychotropic medication, you will need to sign a "Authorization to Release Information/Records" form so that I may confer with your doctor for the purpose of furthering your treatment. If you wish for information to be released to others you will need to also provide a written release of information.

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Appointments

I am usually in the office seeing patients Monday through Thursday. Since successful treatment requires continuity, you should plan ahead to avoid any problems in coming to your appointments. If you need to cancel, please let me know within **24 hours**, so that someone else can use your allotted time slot. If you cancel less than **24 hours** in advance or miss your appointment, you will be billed at the full rate of $150.00. Messages left on my email do not constitute a cancellation; please call the office. The answering machine takes messages 24 hours a day. Also, if you miss an appointment, it is your responsibility to call to set up another one.

Emergencies

If you are in an urgent crisis and need to talk to me, call 834-8341 follow my instructions and leave a message on my voice mail which contacts me. I (or someone covering) will most likely return your call within the hour if you indicate that it is an emergency. You can also contact a Mental Health Outreach Nurse (861-2251), a Psych Tech at Kern Medical Center (861-2665), someone at Memorial Center (398-1800) or dial 911.

Fees

Psychological Testing:	MMP-II with report $450
	Mental Status Exam (MSE) with report $350
	MMPI-II and MSE combined $750
Initial intake interview:	$170.00 55-60 minute session
Psychotherapy Session:	$150.00 45-50 minute session

My basic fee is $150.00 for a 45-50 minute session, payment is required at the time of session. If you are a financially responsible for a patient of mine and you will not be coming with them, you should make arrangements to send a check in advance. If I spend time with you (or your behalf) on the telephone, writing letters/reports, going to court, etc., you will be billed at my basic fee. Failure on your part to comply with the policy will make your account eligible to be given to a collection agency. If your check bounces you will be billed at a $25.00 fee, in addition to the amount owed.

Other issues

If I feel I cannot help you, I will try to refer you to someone who can help you. If you want to get a "second opinion" or a referral to someone else, please ask me. I won't be offended. If you have any questions or complaints at any time, please let me know, especially if you feel I don't understand you or that you can't be open with me about something important. I am in independent practice and not in legal or business association with anyone who may be working out of the same office, suite, floor or building.

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In signing this form (Informed Consent), you acknowledge that you have read these 3 pages and that you understand it and agree with it.

Your Name_____ Date_____

Signature _____

Signature of Financial Responsible Party_____

Superbilll Agreement (Optional)

In signing this superbill agreement, I agree to pay Dr. Gonzales in full ($170.00 - first session, $150.00 - following sessions) at the time of each session. Dr. Gonzales will give me a superbill at the end of session, that I will submit to my insurance company for reimbursement.

Your Name_____ Date_____

Signature_____

Signature of Financial Responsible Party_____

Submit the Yellow Copy to your insurance company. This statement contains all the information the doctor is required to supply. It is not necessary for this office to fill out the insurance company claim form. The Pink copy is for your personal record.

Authorization to Release Information/Records (Optional)

I hereby consent to the release of my medical information/records with Dr. Gonzales for the purpose of medical evaluation and treatment. There is a fee of $15.00 for copies of medical records.

Your Name_____Date_____

Signature_____

Who Would You Like Information/Records Released To:

_____

_____

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Authorization to Release Information/Records

I give my consent to: _____
_____
_____
_____

RE: _____

I hereby consent to the release of my medical records for the purpose of medical evaluation and treatment.

_____ _____
Patient Signature Date Witness Signature Date

_____ _____
Signature of Parent, Guardian, or Authorized Representative Date

Note: There is a fee of $15.00 for copies of medical records.

CALIFORNIA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose you protected health information (PHI), for certain treatment, payment, and health care operations purposes without your authorization. In certain circumstances I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

* "*PHI*" refers to information in your health record that could identify you.
* "*Treatment and Payment Operations*"
  - *Treatment* is when I provide or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when you disclose your PHI to your health insurer to obtain reimbursement for your health care.
  - *Health Care Operations* is when you disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the plan, such as case management and care coordination.
  - "*Use*" applies only to activities with my office/group practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
  - "*Disclosure*" applies to activities outside of my office/group practice, such as releasing, transferring, or providing access to information about you to other parties.
  - "*Authorization*" means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I 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 is not effective until I receive it.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

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

- **Adult and Domestic Abuse**: If I, in my 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 that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency.

I do not have to report such an incident if:

1) I 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) I am 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 metal 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 judgement, I reasonably believe that the abuse did not occur.

- **Health Oversight**: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information form me 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 I have provided you, I 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 me 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 me 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. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety**: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that your are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

- **Worker's Compensation**: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial examination, and at subsequent intervals as may be required by the administration director of the Worker's Compensation Commission in order to determine your eligibility for worker's compensation.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *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, I will send your information to another address.)

- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI 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 discuss with you the details of the request and denial process.

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

- *Right On Accounting* - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

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

Psychologist's Duties:

* I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
* I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

* If I revise my policies and procedures, I will either mail form to you or give you form at your next appointment time.

V. Complaints

If you're concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact my Office Manager.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice, by either mailing form to you or giving you form at your next appointment time.

****

HIPAA (Health Insurance Portability and Accountability Act of 1996) requires that all patients receive California Notice Form and sign this acknowledgment:

Yes, I have received the California Notice Form describing how psychological and medical information may be used and disclosed and how a patient can get access to this information.

Your Name_____ Date_____

Signature_____
(Of Patient or Parent, Guardian, or Authorized Representative)