

Robert J. Solomon, MD

12845 Pointe Del Mar Way, Suite 200, Del Mar, CA 92014

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PATIENT INFORMATION

TODAY'S DATE:		ARE YOU A NEW PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
FIRST NAME		MIDDLE INITIAL	LAST NAME		
MAILING ADDRESS			DATE OF BIRTH		
CITY		STATE		ZIP	
HOME PHONE		CELL PHONE		WORK PHONE	
E-MAIL ADDRESS			STUDENT STATUS: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> None		

RESPONSIBLE PARTY INFORMATION

(Only if DIFFERENT from Patient Information above)

FIRST NAME		MIDDLE INITIAL	LAST NAME		
MAILING ADDRESS			DATE OF BIRTH		
CITY		STATE		ZIP	
RELATIONSHIP TO PATIENT: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (Specify):		SOCIAL SECURITY NUMBER		PHONE NUMBER	

EMERGENCY CONTACT INFORMATION

FIRST NAME		MIDDLE INITIAL	LAST NAME		
MAILING ADDRESS			DATE OF BIRTH		
CITY		STATE		ZIP	
RELATIONSHIP TO PATIENT: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other (Specify):		HOME PHONE		CELL PHONE	

INSURANCE INFORMATION

(Please present your Insurance ID card or provide copies of front & back of card)

<input type="checkbox"/> Please Check Here If You Have NO Insurance And You Will Be Solely Responsible For Payment					
PRIMARY INSURANCE NAME			SECONDARY INSURANCE NAME		
INSURANCE PHONE NUMBER () -		EFFECTIVE DATE	INSURANCE PHONE NUMBER () -		EFFECTIVE DATE
CLAIMS ADDRESS			CLAIMS ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
SUBSCRIBERS NAME (FIRST, M., LAST)			SUBSCRIBERS NAME (FIRST, M., LAST)		
DATE OF BIRTH		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
SUBSCRIBER I.D. #		GROUP #	SUBSCRIBER I.D. #		GROUP #
SUBSCRIBER'S EMPLOYER			SUBSCRIBER'S EMPLOYER		

POLICY STATEMENT

Thank you for choosing me for your **psychiatric** needs. I am committed to your treatment being successful. Please understand that payment of your services is considered part of your treatment. The following sets forth the terms and conditions upon which my services are rendered.

CONSENT OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: I hereby consent to the use or disclosure of my "protected health information" by **Robert J. Solomon, MD, Inc.** for the purpose of diagnosing or providing treatment, or obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis and treatment of me is conditioned upon my consent as evidenced by my signature on this document.

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

My "protected health information" means health information, including my demographic information, collected from me and created or received by this provider, another health care provider, a health plan, my employer or a health care clearinghouse. This "protected health information" relates to my past, present or future physical health, mental health or condition, and identifies me, or if there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the *Notice of Privacy Practices* prior to signing this document. The *Notice of Privacy Practices* is available upon my written request.

The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the duties with respect to my protected health information. I understand that this medical office reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may obtain a revised notice of privacy practices by requesting it in writing, either by mail or at my next appointment, and a revised copy be sent in the mail or will be provided to me at the time of my next appointment.

CONFIDENTIALITY: Professional ethics and California state law specifies that communications to medical staff are confidential and privileged, and cannot be released or shared without the express written permission of the patient, except as noted above. However, there exist a few instances that are mandated by law to report certain information. These include, but are not limited to, abuse of minor, or if you express the intent of bringing harm to yourself or another person. In such circumstances, the provider is required to inform potential victim(s) and legal authorities.

PAYMENT OF FEES: Payment for services is the patient's responsibility (or parent/guardian, if patient is a minor.) I agree to pay my share of the charges, such as co-payment and deductible amounts, at the time of each visit. The charge for each appointment depends upon the time I spend with the physician, and the type of visit for which I am seen. I understand that **Robert J. Solomon, MD, Inc.** fees are within the usual and customary rates for medical services in the San Diego area. For specific dollar amounts, please ask **Robert J. Solomon, MD, Inc.** Please note that **Robert J. Solomon, MD, Inc.** charges a \$25 service fee for all returned checks.

INSURANCE: **Robert J. Solomon, MD, Inc.** will submit your insurance claims to your carrier, at no cost to you. However, he is not in a position to guarantee payment from your insurance company since the claim is based upon arrangements between you and the insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, he may not bill your insurance company; he may be required to bill your medical group or a third party payer. I understand it is my responsibility to know if this is true.

PRIOR AUTHORIZATION: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s).

APPOINTMENTS: Your appointment time has been reserved exclusively for you. I agree that if I fail to cancel my appointment with at least 24 hours advance notice I will be billed for the full fee of the appointment by **Robert J. Solomon, MD, Inc.**

I understand that insurance companies do not cover missed appointments.

MEDICAL RECORDS: I understand that **Robert J. Solomon, MD, Inc.** will retain my medical records for seven years as per legal requirements. Copies of records can be transferred to other health care providers upon receipt of a valid written consent. I understand that his office requires at least 72 hours notice prior to medical records being made available to the authorized party.

MEDICATIONS: I understand that medication refills will be considered during office hours only. This is so his office can conform with California Pharmacy statutes, and to prevent the possibility of other persons from acting or posing as patients of **Robert J. Solomon, MD, Inc.** or obtaining medication illegally. I further understand that if I should need to have a prescription refilled that I should contact my pharmacy at least 1-2 days prior to needing the medication or the medication may not be available to me the same day. I understand refills for any medication will not be performed unless I have been seen within the last six months.

AGREEMENTS: I have reviewed the preceding information and I certify that this information is accurate. I further understand that I am responsible for any financial loss due to incomplete or inaccurate information provided by me. I hereby authorize payment directly to this medical provider any insurance benefits that would otherwise be payable to me for services rendered. In instances where insurance does not pay any benefits, I agree to pay for those services. If payment is not received within 90-days from the date the claim was submitted, I agree that I will become responsible for the full amount of the balance on my account. Should I break the financial arrangements as detailed above, I agree that my name may be released for collection purposes. I understand that no treatment related information will accompany this disclosure. I also agree that if any legal action is taken to enforce the provisions of this Policy Statement that the prevailing party shall be entitled to reasonable attorney's fees and costs.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE INFORMATION

Client/Legal Representative Signature

Provider Signature & License #

Date