TRI VALLEY MEDICAL CENTER
2324 SANTA RITA ROAD, SUITE 16
PLEASANTON, CALIFORNIA
94566

MAILING ADDRESS:
POST OFFICE BOX 849
LIVERMORE, CALIFORNIA
94551

COMPREHENSIVE NEUROPSYCHIATRIC SERVICES MEDICAL GROUP
A Professional Medical Corporation

DANIEL JON KOSTALNICK, MD, FAPA
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
DIPLOMATE, NATIONAL BOARD OF PHYSICIANS AND SURGEONS

OFFICE 925.784.4000
FACSIMILE 925.426.0085

ASKMYDOCTOR@ME.COM
WWW.CNSMEDICAL.COM

Welcome to Comprehensive Neuropsychiatric Services Medical Group
CNS Medical Group, APMC
A Professional Medical Corporation

—A Private and Independent Medical Practice—

This packet will help answer some of your questions about the practice prior to our first appointment together.

In preparation for our first meeting, please take a few minutes to complete and sign the information in this packet and return it by scanning and emailing it as ***one .pdf document*** to askmydoctor@me.com or you may ***fax it to 925-426-0085***. It is important that the ***entire packet be completed and returned in order to schedule your appointment.***

My continued goal is to provide excellent psychiatric medical care that is both comprehensive and personalized. Please let me know how to best serve you as we work together. Patient satisfaction and the professional relationship of mutual trust and respect is an integral part of our work together.

This first appointment is for an initial consultation—a time when we can meet in person and discuss your medical and psychiatric needs and concerns. Most importantly, it is when we will decide if it is in our shared best interests to work together. There may be unusual circumstances when I will not be able to assume care as your physician. This may be due to a variety of reasons. At the end of our initial consultation, we will make the decision whether to begin a doctor-patient relationship and form a treatment plan.

Office Address
Tri Valley Medical and Professional Center
2324 Santa Rita Road, Suite 16
Pleasanton, CA 94566

Telephone: 925.784.4000
Facsimile: 925.426.0085

Email: askmydoctor@me.com
URL: www.CNSmedical.com

Directions to the Pleasanton Office

From San Francisco: Take the **580 FREEWAY EAST** toward Stockton. In Pleasanton, take the **SANTA RITA ROAD** exit and make a **RIGHT** toward downtown Pleasanton. Proceed on Santa Rita Road to **MOHR AVENUE** and make a **LEFT** on Mohr Avenue. The Tri Valley Medical Center building is immediately on your left, at the corner of Santa Rita Road and Mohr Avenue.

From Stockton: Take the **580 FREEWAY WEST** toward San Francisco. In Pleasanton, take the **SANTA RITA ROAD** exit and make a **LEFT** toward downtown Pleasanton. Proceed on Santa Rita Road to **MOHR AVENUE** and make a **LEFT** on Mohr Avenue. The Tri Valley Medical Center building is immediately on your left, at the corner of Santa Rita Road and Mohr Avenue.

Dr. Kostalnick (CNS Medical Group, APMC) is in Suite 16.

Once in the suite waiting room, please make yourself comfortable after you turn on the indicator light near the interior door where the clinician name(s) are listed. My notification switch is marked with my name.

PATIENT INFORMATION SHEET

Date: 08/07/2023

Name: Yuh-Boh Feng

Date of birth: 08/12/1993

Social Security number: 610-59-4411

Driver's license number: F4511899

Address: 1191 Vista Ridge Ct 94518 Concord, CA

Home phone:

Work phone:

Mobile phone: 408-966-0484

Email address: fengyuhboh@gmail.com

May I contact you and leave a detailed message for you via email, text, and voicemail?

Yes

Name and phone number of parents (if patient is a minor):

Name and phone number of spouse/partner (if any):

Who referred you to my practice?

Peggy Wong

Primary Care/Family Physician

Name:

Telephone:

Therapist (if any)

Name:

Telephone:

Emergency contact:

Name: Julia King

Phone numbers: 925-477-0116

Relationship: Mother

Please notify Dr. Kostalnick if any of the information on this form changes in the future.

SESSION FEES AND CHARGES

1. FIRST APPOINTMENT:

INITIAL EVALUATION: $650

(THIS FEE IS ALL-INCLUSIVE FOR THE FIRST APPOINTMENT PROFESSIONAL FEES.)

The time spent in an initial evaluation may vary. I spend as much time as necessary to come up with the best way for us to begin to work together on solutions, while being as efficient as possible.

Our initial meeting together will usually last between 45 to 50 minutes.

2. FOLLOW UP APPOINTMENTS:

A. PSYCHOTHERAPY (WITH OR WITHOUT MEDICATION MANAGEMENT)
(APPROXIMATELY 45 MINUTE SESSION): $325

B. PSYCHOPHARMACOLOGY MEDICATION MANAGEMENT
(UP TO 15 MINUTES / MEDICAL APPOINTMENT): $225

C. URGENT/OVERBOOK APPOINTMENTS
(COST DETERMINED RELATIVE TO COMPLEXITY AND TIME PER CURRENT SESSION RATES)

3. ON-CALL URGENT/ EMERGENCY PHYSICIAN OR NURSING SERVICES:

URGENT CONTACT TO EITHER DR. KOSTALNICK, THE NURSE/CLINICAL COORDINATOR, OR THE ON CALL SERVICE, INCLUDING AFTER BUSINESS HOURS MONDAY THROUGH FRIDAY, WEEKENDS, AND HOLIDAYS MAY RESULT IN EMERGENCY/URGENT CALL BILLING AT $50.00 PER 10 MINUTE INTERVAL. THERE IS A MINIMUM CHARGE OF $50.00 FOR URGENT/EMERGENCY CALLS TO THE PHYSICIAN, NURSE CLINICAL COORDINATOR, OR ON-CALL SERVICE.

4. INCIDENTAL CHARGES:

URGENT CLINICAL TELEPHONE CALLS OUTSIDE OF APPOINTMENT TIMES: $50, PER TEN MINUTE INTERVAL

RETURNED CHECK FEE OR LATE PAYMENT FEE (INCLUDING BANK AND ADMINISTRATIVE COSTS) $50.00

ADMINISTRATIVE REQUESTS (FOR EXAMPLE: DISABILITY FORMS, INSURANCE FORMS, PRIOR AUTHORIZATION REQUESTS TO INSURANCE COMPANIES, CARE COORDINATION, LETTERS ON YOUR BEHALF, REFILL OF MEDICATION) ARE BILLED PER ACTUAL TIME REQUIRED FOR COMPLETION AT THE RATE OF $50 PER TEN MINUTE INTERVAL.

Initials: YF Date: 08/07/2023

Patient Agreements to
CNS Medical Group, APMC

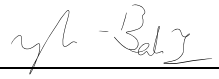
1. There is a charge for appointments missed, rescheduled, or cancelled less than FORTY-EIGHT (48) BUSINESS HOURS in advance, equal to the fee of the scheduled appointment regardless of cause. (Please note that MONDAY appointments MUST be canceled by the prior Friday by 5pm.) This policy includes the initial consultation session. This policy is in place for several reasons and applied equally to all patients in the practice.

2. All fees must be paid in full at the time of the session.

3. A receipt (called a 'SuperBill') will be given at the time of the session that you may submit to your insurance company for reimbursement, unless you intend to submit to MEDICARE/MEDI-CAL. Medicare and Medi-Cal are currently *not* accepted in the practice. Insurance companies are not directly billed for services—although reasonable help obtaining reimbursement from your insurance company may be provided.

4. If your check is returned, payment in the amount of the check plus $50 processing and accounting fee will be due. If you have a credit card on file, your card will be billed for any outstanding charges automatically.

5. It is important that you know how to contact your doctor. Please use the main telephone number first (**925-784-4000**). Once you are en established patient (after our first appointment) and the matter is urgent, first leave a message at the main telephone number (**925-784-4000**) and then hang up and call again within two minutes ***and leave a second voicemail*** message at the same phone number/voicemail. *Though I do not have an emergency psychiatric practice*, this will alert me to a more urgent matter. If you do not receive a return call in what you believe is a reasonable amount of time, please call again. Always follow the voicemail instructions for contacting the on-call covering clinician if Dr. Kostalnick is away from the office (the voicemail outgoing message will give you any needed instructions in that case.)

Signature:  Date: 08/07/2023

CONSENT TO MEDICAL CARE AND TREATMENT

There are risks involved in any medical procedure or treatment. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned treatment. It is also not possible to consent to treatment prior to having the treatment explained to you. This information and consent serves to make known the possible risks and complications in a general way. Most importantly, your understanding of the risks and complications is very important. Please ask any questions about your care at any time—and only proceed with the recommended treatment plan when you are comfortable with the plan of care and completely understand the plan of care and its potential complications and risks. Your questions are always welcome!

I authorize Dr. Kostalnick and such physicians, associates, therapists, nurses, administrative assistants, and other personnel chosen by him to perform mental health, medical, psychotherapy, administrative and/or treatment with psychiatric and other medications, and to do any other procedures that in their judgment may be advisable to my well-being, including such procedures as are considered medically advisable to remedy conditions discovered during the above treatment or procedures. I agree that this authorization will cover retroactively any medical services rendered before the date it is signed and will be effective as of the date of first medical services (including, but not limited to, emergency treatment). I understand that it is my responsibility to ask any questions at the time a treatment is recommended and this form serves also to acknowledge that I shall agree to give or deny my consent at the time of treatment(s) only after I am comfortable with the explanation of the plan of care and treatment.

• **RISKS AND COMPLICATIONS**. I am satisfied with my understanding of the more common risks and complications of the treatment or procedure, which I have discussed in detail with my physician, Dr. Kostalnick. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. The risks of treatment include, but are not limited to the following: the risk of drug reactions or their sequelae, worsening psychiatric illness, suicidality, homicidality, grave disability, permanent medical conditions (i.e., movement disorders, diabetes) or death. I am aware that as treatment and our doctor-patient relationship continues, I will ask for clarification about the risks and complications of treatment or non-treatment and will be responsible to fully participate in my healthcare on an ongoing basis.

• **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including, but not limited to: psychotherapy without the use of medications, medications without the use of psychotherapy, and general information about psychiatric conditions and their diagnosis and treatment.

• **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes, or risks if no treatment is received or rendered.

• **SECOND OPINION.** I understand that I have the opportunity to seek a second opinion concerning the proposed treatment or procedure. I understand that seeking a second opinion, or asking for a consultation about my case from another qualified medical doctor, is an option for me and that Dr. Kostalnick is willing to confer with my other healthcare providers, as necessary.

• **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that conditions may arise that are unforeseen at this time and that it may be necessary and advisable to perform treatment or procedures different from, or in addition to, the treatments and procedures planned. I understand that I will be asked to authorize and consent to the performance of such additional or different treatments and procedures, as are considered necessary and advisable by my physician, at such time and this may be documented in the chart.

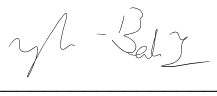
• **ELECTRONIC MEDIA.** I understand that the content of email and/or text and/or facsimile or other electronic media communications may become part of my medical chart.

• **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

• **OTHER QUESTIONS.** I agree that I am satisfied with my understanding of the nature of the treatments and/or procedures and all of my questions about the treatments or procedures have been answered. It is my responsibility to ask Dr. Kostalnick about my medical care and treatment when I do not understand or would like further clarification.

Initials: YF Date: 08/07/2023

- **Other Therapists/Split Treatment.** Many patients are in therapy with a therapist other than Dr. Kostalnick. I understand that it is not possible for Dr. Kostalnick to monitor, nor be held responsible, for the actions (or lack of action) of another practitioner. I understand that if I desire, Dr. Kostalnick will attempt to coordinate my care with other providers. However, Dr. Kostalnick is not responsible for the care provided by others nor is Dr. Kostalnick in the position of supervising other practitioners (unless otherwise noted) even if the provider was recommended by Dr. Kostalnick. I further understand that Dr. Kostalnick makes no representation nor assumes responsibility for the other independent practitioners in his shared office space. I further understand that if I have questions about my therapy, the therapist, or any concerns about "split treatment" I am encouraged to ask Dr. Kostalnick and my therapist.
- **Urgencies and Emergencies.** Dr. Kostalnick is available to patients outside of the regular appointments on a limited basis, as his time is spent with other patients and duties. Please note that this is not an emergency psychiatric practice. If there is a medical and/or psychiatric emergency, I must call 911 or go to the nearest emergency department at my local hospital. (Examples of emergencies include medication reactions that are severe and potentially life threatening, suicidal or homicidal thoughts with the intention to carry them out.) If it is an urgent matter, which requires Dr. Kostalnick's more immediate attention (and cannot wait for a call-back at the end of the business day/next business day) I will call the office number and follow the instructions to have Dr. Kostalnick notified of an urgent matter. Please note, these calls interrupt other patient sessions and must be reserved for urgent issues only. (Examples of urgent matters include suicidal or homicidal thoughts that are increasing in severity but not an imminent threat of being carried out or questions related to medications, such as minor reactions.)
- **Telephone Contact.** Routine calls are checked periodically, throughout the business day (Monday through Friday) and are generally returned within 24 hours, unless otherwise stated. Calls left after 5:00PM on Friday may not be returned until the following Monday (or next business day, if Monday is a holiday.) If you do not receive a call-back in what you believe is a reasonable amount of time, please call again and ask for a call-back more immediately. Always leave your full name and phone number, even if you think I have this information.
- **Medication consent.** Medication comes with both potential risks and benefits and complications or adverse medication reactions are possible. It is imperative that you understand the risks and benefits as well as the potential complications, side effects, adverse events and the long-term risks of taking medications. You are not compelled to take medications, however if you and Dr. Kostalnick agree that medication is indicated please only fill prescriptions for which a discussion of the risks, benefits, complications, alternatives, side effects, and adverse event potential has been discussed. Your pharmacy will frequently give you a hand-out on the medication as well—however this is not a substitute for a conversation about the medication with Dr. Kostalnick. Please only fill the prescription(s) after this discussion about medication has been completed with Dr. Kostalnick and that you feel comfortable with the associated risks. Filling a prescription at the pharmacy constitutes your consent to take the medication and that you and Dr. Kostalnick have discussed the medication in detail to your level of understanding and satisfaction. Please ask Dr. Kostalnick about your medications should there be any questions or concerns.
- **Pregnancy/Women of Child-bearing age.** Because medication and treatment can be potentially harmful and/or fatal to the developing fetus and mother, please let Dr. Kostalnick know immediately if you are pregnant or plan to become pregnant. If you become pregnant during your treatment, please notify Dr. Kostalnick immediately.

SIGNATURE:  Date: 08/07/2023

A Message to Patients about Medical and Psychiatric Risks

Medicine, psychiatry, and associated medical and mental healthcare services are usually safe, helpful, and may be lifesaving. However, medical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death). It is important to be aware of the following possible risks before receiving the treatment you and your physician are planning. The following may be the reactions of your mind and body to medical or psychiatric treatments or procedures.

1. Drug reactions: Unexpected allergies, lack of proper response to medications, or illness caused by the prescribed drugs are possibilities. It is important for you to inform your physician and any other medical or surgical personnel involved in your care of any problem you or your family have had with reactions to drugs, and which medications you have taken in the past six months, including over-the-counter drugs, supplements, and herbal remedies.

2. Worsening medical or psychiatric illness: It is possible that your psychiatric or other medical illnesses may worsen despite, or as a result of, receiving treatment. It is important for you to inform your physician of all of your medical and psychiatric conditions, past and present. It is also important for you to inform your physician if you notice a worsening of the symptoms and signs of your illness, or develop any new symptoms and signs. Worsening psychiatric illness may include symptoms such as suicidality or homicidality. It is absolutely necessary that you contact your physician, go to an emergency room, or seek medical assistance by other means such as calling 911, if thoughts of suicide or homicide exist or worsen. It is also possible that psychiatric and other illnesses may eventually cause grave disability or death, with or without treatment.

3. Other risks: It is not possible to list all the possible risks and complications, and their variations, that may arise in any medical or psychiatric procedure. Each situation depends upon the purpose and nature of the procedures. Your physician is willing to discuss further with you various details about other risks.

Alternatives to Treatment

Although you and your doctor have decided upon a particular course of treatment and/or procedure, do not hesitate to discuss the reasons for the choice and the alternatives available for treatment of your condition. In addition, be sure to ask your doctor any other questions that you may have about your treatment at any time.

I have read, understood, and agree to the above terms.

Signature:  Date: 08/07/2023

Electronic Communication Safe Practices

AskMyDoctor@me.com
www.CNSmedical.com

You have asked to communicate with our office using electronic means such as email. To do so with safety and confidence, you must understand and agree to our guidelines. Please read the following information about this communication and our policy. If you have any questions about what you read, please ask Dr. Kostalnick.

Following this information is an agreement that will help to protect your well-being and your confidentiality. If you understand our policies—and agree to adhere to them—please sign and date the form.

- **Please be aware that email communication is not a substitute for face-to-face encounter with your physician**
- It is our practice to make every effort to protect your confidential information and all communication. We acknowledge, however, that no electronic media is 100% secure. Even the most carefully protected messages are stored on a computer's hard drive. Though it is unlikely, this information could be retrievable. We cannot guarantee against unknown privacy violations such as unauthorized access achieved by illegal activity.
- We ask you to limit your email communication with us to ask the following: routine, non-urgent administrative questions. You may also use email to "check in" with Dr. Kostalnick, as directed.
- We will communicate with you by email only if you are an established patient. That means that we will communicate with one another only in the context of care that began with a face-to-face encounter where we agreed to establish a doctor-patient relationship.
- All email communication may be printed out and/or a hard copy/scanned copy may be filed in your chart. An electronic copy of your email communication may be filed in your chart.
- We will try to respond to email messages within 5 business days (Monday through Thursday, excluding holidays.) However, there is no way to guarantee that this will occur, for a variety of reasons (misaddressed email, server delays/down, power failures, etc.) If you do not get a response from your email within the time frame specified above, it is up to you to contact us by telephone at 925-784-4000.
- We do not accept medication refill requests by email unless the request was preceded by a recent examination in the office. You must have an appointment to continue to have refills of medication every 3 months (quarterly). Please make certain that you have your appointments scheduled accordingly in the event of a cancelation or rescheduled appointment. Even then, safe medical practice may mean that it is necessary for you to be seen before we can refill your medication. As always, please first contact your pharmacy and ask that they will send a refill request to our office by electronic prescribing or by calling the voicemail at 925-784-4000. If you or the pharmacy does not get a response from this office, please call the main phone number at 925-784-4000 and leave a message regarding the medication refill request. As always, please allow up to 7 business days to process your refill request, though most refill requests are responded to within the same day.
- If we are out of the office, or if we are with other patients, the nurse clinical coordinator may read and/or print out email messages for us and, at our direction, may respond to you on our behalf.
- If you fail to adhere to our email policies, we may need to discontinue our communication using email.
- PLEASE KNOW THAT ANY TIME DR.KOSTALNICK IS AWAY FROM THE OFFICE, HE MAY NOT RECEIVE ELECTRONIC COMMUNICATION. IF YOU DO NOT RECEIVE AN ELECTRONIC RESPONSE IN A REASONABLE AMOUNT OF TIME, PLEASE CALL THE MAIN PHONE NUMBER (925-784-4000) AND FOLLOW THE DIRECTIONS FOR CONTACTING THE ON-CALL DOCTOR OR TRIAGE NURSE.
- UNDER NO CIRCUMSTANCES SHALL EMAIL CONTAIN EMERGENCY OR URGENT INFORMATION—IN EMERGENCIES OR URGENT SITUATIONS, PLEASE CALL THE MAIN PHONE NUMBER AND FOLLOW THE INSTRUCTIONS ON THAT VOICEMAIL SYSTEM OR CALL 911 OR PROCEED TO YOUR NEAREST EMERGENCY ROOM FOR EVALUATION AND TREATMENT.

Initials: YF Date: 08/07/2023

OUR AGREEMENT REGARDING ELECTRONIC COMMUNICATION

I wish to communicate with Daniel Kostalnick, MD/Comprehensive Neuropsychiatric Services Medical Group, A Professional Medical Corporation/CNS Medical Group via electronic communication. I realize that this is not 100% reliable nor secure, but I acknowledge that the doctors and their staff assured me that they will make every effort to protect my privacy, and I wish to use these means to communicate with them.

1. I am aware and agree that a hard copy and/or an electronic copy of email communication may be filed in my medical chart
2. I agree to include my name, home/mailing address, and telephone number in the body of all email I send to Dr. Kostalnick/CNS Medical Group to ensure that they have an alternate means of contacting me.
3. I will limit my email to certain routine/non-clinical questions, as outlined above.
4. I agree to fill in the subject line of each email to alert Dr. Kostalnick and the CNS Medical Group Staff of the purpose of the message
5. I will not use electronic communication regarding emergencies or urgencies. I am aware that time-sensitive matters are not appropriate for electronic communication.
6. I will not communicate by email about information or questions related to 1) highly sensitive subjects such as HIV/AIDS or Sexually Transmitted Diseases; 2) questions/problems of a sexual nature; 3) Alcohol or Drug dependence or treatment; or 4) specific mental health questions.
7. If I do not get a response to my electronic communiction within the time-frame specified above (5 business days) I will contact the office via telephone at 925-784-4000.
8. I know that I am responsible for following the medical advice Dr. Kostalnick or his representative conveys to me by email.
9. I accept that if I fail to follow this agreement related to our communication, or if the doctor determines that it is not in the best interest of my medical care to use electronic means to communicate with him or the office, I may be limited to only using more traditional means—such as telephone contact or U.S. Mail.
10. I request and authorize the doctors or their staff to communicate my pertinent medical and psychiatric information via electronic communication.
11. I have asked all the questions I had about the electronic communication policies, and my questions have been answered to my satisfaction. I understand the policies and agree to abide by them in full.
12. Finally, I agree to pay the email consultation fees for email/internet communication/online consultation. Please be advised that the standard fees apply, i.e., currently $50.00 per 10 minute interval/event (minimum charge is $50.00)

SIGNATURE:  DATE: 08/07/2023

CONSENT TO OBTAIN AND/OR RELEASE INFORMATION FROM MEDICAL RECORDS

OBTAIN MEDICAL RECORDS/INFORMATION

□□I, the undersigned, hereby authorize Dr. Kostalnick to **OBTAIN** the following types of information related to my care FROM the physician, individual, organization, or agency specified below.

RELEASE MEDICAL RECORDS/INFORMATION

o□I, the undersigned, hereby authorize Dr. Kostalnick to **RELEASE, DISCUSS, OR OTHERWISE PROVIDE** the following types of information related my care TO the physician, individual, organization, or agency specified below.

INFORMATION TYPES TO BE OBTAINED

Initial: YF Psychiatric Information
Initial: YF Drug/Alcohol-related
Initial: YF HIV testing/results, or AIDS
Initial: YF Other Medical Information

INFORMATION TYPES TO BE RELEASED

Initial: YF Psychiatric Information
Initial: YF Drug/Alcohol-related
Initial: YF HIV testing/results, or AIDS
Initial: YF Other Medical Information

RECORDS TO BE OBTAINED FROM AND/OR RELEASED TO:

(Fax) _____

_____ (Phone) _____

Physician, Individual, Organization, or Agency

_____ _____

Street Address City

_____

State

_____

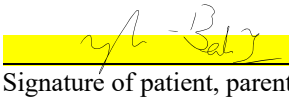
Zip

FOR THE PURPOSE OF: □□Coordinating patient care □□ Exchange of information

I understand that only the types of information initialed above will be obtained and/or released. I further understand that this consent is effective immediately, and I may withdraw it at any time. I understand if I withdraw this consent after information has been exchanged in accordance with the permission granted herein, such withdrawal will not rescind, or retroactively nullify, cancel, or otherwise render void consent for the prior exchange of information. I further understand any withdrawal of consent will only become valid and applicable from that date and time Dr. Kostalnick receives and becomes aware of written notice of such withdrawal.

I am advised of, and understand, my right to receive a copy of this authorization upon request.

Yuh-Boh Feng
Print Patient Name


Signature of patient, parent, or legal guardian

08/07/2023
Date

Release or transfer of the above information to any other person or organization is prohibited. An additional written consent must be obtained if any of the above information is to be transferred to or obtained from another person or organization. A copy or facsimile of this authorization shall be considered as effective and valid as the original. This consent is valid for a period of ten (10) years from date signed, unless otherwise indicated. Indication for continued consent beyond the ten-year stipulation may include documentation in the chart.

First Appointment Information

1. **Today's Date**: 08/07/2023

2. **History of the presenting concern:** (***In your own words, describe the reason for your appointment.)***
Please be as specific as possible—you may type out a description in a Word document, if you prefer. You may think of the prompt to this question as, "I was in my usual state of good health and things were going well until…"

Depression and suicidal thoughts due to job rejections. Realized that my career has been stagnating and comparing myself others. Feeling lost and incompetent.

3. **Please Circle All That Apply To You**:

-Depression
-Mania/hypomania
-Anxiety
-Panic Attacks
-Psychosis
-Hearing Voices
-Seeing Things
-Paranoia
-Dementia
-Suicidal Thoughts
-Homicidal Thoughts
-Stress
-Self Harm
-Cutting
-Impaired Functioning
-Social Problems
-Parent/Child Conflicts
-Family Conflicts
-Separation or Divorce
-Sexual Problems
-Interpersonal Problems
-Loss
-Death
-Grief
-Addiction/Alcohol, Drugs
-Fire Setting
-School Avoidance
-Work Avoidance
-Work Fears
-Lying
-Stealing
-Sleep problems
-Depressed mood
-Irritable

-No interest
-Weight changes
-Appetite changes
-Sleeping too little
-Sleeping too much
-Fatigue
-Helplessness
-Hopelessness
-Worthlessness
-Feeling guilty
-Poor self esteem
-Concentration difficulty
-Crying spells
-Sex drive changes
-Sexual problems
-Isolation from others
-Feeling shaky
-Muscular tension
-Restlessness
-Shortness of breath
-Racing heart
-Sweating or perspiration
-Dry mouth
-Diarrhea
-Constipation
-Urgent or frequent urination
-Hot flashes
-Lump in throat
-On edge
-Easily startled
-Mind goes blank
-Dizziness or vertigo
-Feeling as if you are "unreal"
-Feelings the life is not worth living

-Fears of dying
-Fears of losing control
-Fears of going crazy
-Fears of leaving home
-Anxiety in social situations
-Performance anxiety
-Obsessive thoughts
-Compulsive behaviors
-Nightmares
-Bedwetting
-Night terrors
-Hearing voices
-Others are out to get me
-Others are keeping track of me
-Unusual beliefs
-Others put thoughts in my head

-I receive special messages from TV or Radio
-I have special powers
-Confusion
-Poor attention
-Poor concentration
-Decreased need for sleep
-Rapid speech
-Mood swings
-Racing thoughts
-Risky behaviors
-Spending too much money
-Excessive religious behaviors
-Hypersexual
-Excess energy

4. **Past Psychiatric History** (describe ALL past mental health, drug/alcohol treatments) including hospitalizations and outpatient psychiatrists/therapists/psychologists.

5. **Current and Past Psychiatric Medications** (name, dose, frequency taken as well as how you responded.)

CURRENT: Lexapro, 10MG, 1 tablet/day, no changes

PAST:

6. **Current Non-Psychiatric/General Medications** (please include Herbals, Supplements, Over-the-counter medications such as pain medicines, vitamins and minerals, et cetera.)

7. **Current Medical Diagnoses** (Issues for which you see a physician or clinical health care provider):

8. **Past Medical Diagnoses** (Issues for which you have seen a physician or clinical health care provider):

7. Other Psychiatric History

Suicide attempts:

Homicide attempts:

Self-Harm: sometimes

History of violence:

Harm to others:

Abuse to you: sometimes

Abuse by you:

Legal Problems:

Eating disorders: sometimes

Developmental delays/Learning problems:

Divorce(s):

Military history: Army Reserves 2018-present

Trauma Exposure, i.e, combat, sexual assault:

Do you have access to guns or weapons?
No

8. **Family History of Psychiatric Diagnoses** (Describe diagnosis, relationship to you. Please include any family history of suicide attempts or self harm.)

9. **Substance Abuse History** (substance, age at which you started and/or stopped using, currently usage.)

10. Do you have **allergies to foods or medicines**? (If so, please list them and your reaction.)

11. Have you had any **medical or other lab testing** within the last 6 months? (i.e., MRI, CT scans, psychological tests.)

Female Patients:

a. Are you able to become pregnant? Y/N

b. Are you planning to become pregnant in the next one year? Y/N

c. Are you pregnant NOW? Y/N

d. Date of Last Menstrual Period: ___/___/___

Credit Card/Electronic Payment

Please note that this authorization must be returned and on file for all patients to schedule an appointment, regardless of method of payment you prefer at the time of appointment.

You may elect to pay by check or another means at the time of service. Additionally, your insurance company may have issued a "health savings" credit card or "flexible spending" card that can be used directly by providing that information on this form.

Credit Card Recurring Payment Authorization Form
Schedule your payments to be automatically charged to your credit card.

Here is how payments are processed:
You authorize charges to your credit card and debit card (Visa or MasterCard) which can be either a credit card/debit card or your HEALTH/MEDICAL SAVINGS ACCOUNT card or FLEXIBLE SPENDING ACCOUNT card. You will be charged each appointment for the total amount due on your account. This includes charges incurred for telemedicine and incidental charges to your account. A receipt may be emailed to you and the charge will appear on your credit card statement. You agree that no prior-notification will be provided to you if the total payment is under $600.00

Please complete the information below:

I, _____, authorize CNS Medical Group, APMC to charge my credit card or debit the account(s) indicated below on or after the date of service for payment of my medical and/or practice expenses. I understand that I will only receive advance notice of the charge if it exceeds $600.00.

Billing Address 5211 Demarcus Blvd. Apt 139

City, State, Zip Dublin CA 94568

SIGNATURE: _____

Phone# 925-477-0116 Email yatowking@gmail.com

DATE: 08/07/2023

Account Type: Visa (MasterCard)

Cardholder Name: Huei-Kao King

Account Number: 5424 1814 7673 7650

Expiration Date: 10/2026

CVV (3 digit number on back of Visa/MC, next to your signature): 973

I authorize the named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form