Vista Mental Health

12560 W Washington Blvd. Los Angeles, CA 90066

*Please read and complete each of the sections listed below as completely as possible.*

**BIOFEEDBACK INTAKE FORMS**

- Name (First, Middle, Last): _____
- Have you ever gone by any other name? If yes, please specify:
  _____
- Date of birth: _____ Sex: M / F Marital Status: _____
- Street Address: _____
  City: _____ State: _____ Zip: _____
- Email address: _____
- Phone Numbers (Please check the box if able to leave a detailed message):

  ☐ Home: _____ ☐ Work: _____ ☐ Cell: _____

Medical and Referral Information

Name of Primary Care Physician: _____

Telephone Number of Primary Care Physician: _____

Address of Primary Care Physician: _____

May I contact your health care provider in the future? Yes No

Who referred you to our practice? _____

Please list names and contact information for any doctors and/or therapists that have been significantly involved in your care over the last ten years.

_____

_____

_____

**Emergency Contact**

Who should we contact in case of emergency? _____

Relationship to you? _____ Phone number _____

## Medical History

Current medical problems (please include date of onset):_____

_____

Past medical problems and/or surgical history (with dates): _____

_____

Do you have a pacemaker? ☐ YES ☐ NO

Have you been diagnosed with epilepsy or seizures? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO

Past mental health treatment (location, dates, provider names, and any other relevant information):

_____

Family Medical/Mental Health/Drug/Alcohol History (siblings, parents, children, aunts/uncles):

_____

Current medications (name/dosage/frequency/reason for taking the medication):

_____

Supplements, vitamins, or herbs: _____

Drug or alcohol use (include amount and frequency): _____

_____

Exercise (frequency & type): _____

## Presenting Issues

Symptoms and duration:

_____

_____

_____

_____

**Authorization to Release Patient Health Information for**

**Treatment, Billing, or Healthcare Operations**

I understand that Vista Mental Health reserves the right to change their notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing. I understand that the Vista Mental Health staff are not required to adhere to these restrictions requested in the event of a potentially life threatening emergency.

Records may be needed in order to process a claim for mental health services. I authorize providers at Vista Mental Health to release information needed for billing purposes to entities that may provide services pertaining to my visit. I understand that by signing below, I am authorizing the release of all or part of my record for the purpose of billing, treatment, or pertinent healthcare operations.

Patient/Guardian Signature_____ Date_____

Patient/Guardian Printed Name_____

I authorize Vista Mental Health to discuss my mental health care to any and all past or present treating health professionals as well as the following (*please list* any friends or family members that you may want to have included in your treatment):

_____

I am aware that this information may pertain to my mental health condition and/or treatment of substance abuse. I execute the release of this information.

Patient/Guardian Signature _____Date_____

Patient/Guardian Printed Name_____

## Agreement for Service / Informed Consent

This agreement has been created for the purpose of outlining the terms and conditions of services to be provided by technician for _____ (herein "Client") and is intended to provide important information regarding practices, policies and procedures of technician, and to clarify the terms of the professional therapeutic relationship between technician and client.

I understand that the intended purpose of biofeedback training is for relaxation and muscle reeducation so I may learn to: 1) reduce my stress, 2) manage my pain, and/or 3) improve the quality of my life. I understand that biofeedback training is considered safe. I further understand that biofeedback is not a substitute for effective standard medical, chiropractic or psychotherapy treatment. Vista Mental Health has advised me to continue ongoing medical treatment and therapies until otherwise advised by my medical physician or medical practitioner. I further understand it is my responsibility to ask my medical doctor for permission to undergo biofeedback training if I wear a peacemaker or have any medical condition that may be exacerbated by relaxation. I understand it is my responsibility to monitor the effects of biofeedback training and to continue the training for as long as it is beneficial to me. I further understand that research suggests that while most people gain considerable benefits from quantum biofeedback training, I understand there is no guarantee that it will.

Patient/Guardian Signature _____Date_____

Patient/Guardian Printed Name_____

## Notice of Office Policies and Procedures

Patient Records

A secured electronic record is kept of services you receive in this office. You have the right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize, in writing, that copies of the record be released to entities you designate. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider.

Methods of Communication and Execution of Clinical Care

You can generally expect a return call within two business days that a message is left. Should there be an emergency or concern for imminent health or the safety of yourself or another person, please call 911 or go to the nearest emergency room immediately.

Hospitalization

Should you require hospitalization, please go to your nearest emergency room or dial 911. Staff at Vista Mental Health do not have admitting privileges at the hospital. Should you need to be admitted, they can communicate with the inpatient treatment team to let them know about your prior treatment.

## Consent for Additional Services

Consent for Teletherapy:

Providers can use video conferencing to see clients, should that be the best option for the technician and client. Please keep in mind that this is up to the discretion of the provider. Also, please note that if you plan to submit your superbill to your insurance company for reimbursement, they may not reimburse as much as they would if you were seen in the office.

Patient/Guardian Signature_____ Date_____

Patient/Guardian Printed Name_____

Consent for Email and/ or Text Messages

I understand that Vista Mental Health cannot guarantee the confidentiality of any email communications and will not be liable for improper disclosure of confidential information and/or breaches in confidentially caused by me or a third party. I understand that Vista Mental Health has no control over the security or management of my individual email service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient. I further understand and agree that: email will not be used in emergencies and I agree to call 911 in the event of an emergency, emails will be answered within a maximum of 7 business days and that a prompt reply may not be available during weekends or holidays, I must include my full name and date of birth in every email message I send, I understand and agree that providers may choose to stop electronic communications with me at any time, and I understand that the confidentiality of my individually identifiable health information may be compromised when such is sent through email. I agree to the requirements listed above and hereby voluntarily request and consent to communicate with therapist and/or office personnel by email or text.

Patient/Guardian Signature_____ Date_____

Patient/Guardian Printed Name_____

## Insurance Benefits and Patient Responsibilities for Fees

We do not participate as a contracted provider for any insurance companies, but can provide you with a superbill (a detailed receipt of services provided) that you may submit to your insurance company. They may or may not provide some direct reimbursement to you. Payment is due at the time the service is rendered. We accept cash, check, and major credit cards. It is required that a credit card be kept on file. This card will be charged the **full fee for failure to keep any scheduled appointments without 24 hours prior notification** (or one business day- so in the case of weekends and holidays, cancellations will need to be made more than 24 hours in advance) and will also be used to when billing for phone calls. Phone calls longer than ten minutes may be charged as a full session. Any outstanding fees will be charged to the card designated on this form.

| CPT | DESCRIPTION OF PROCEDURE | MINUTES | FEE |
|---|---|---|---|
| **90901** | Biofeedback | 50 | $125 |
| | Biofeedback (practice session) | 25 | $65 |

Forms/letters: $50-$200 (Variable/time dependent) Insufficient funds/returned check fee: $50

*I understand and accept the terms of the charges, cancellation fees, insufficient funds/ returned check fees and no-show policy as outlined above and authorize Vista Mental Health (or Dr. Deborah Fein Medical Corp) to charge my credit card or checking account accordingly.*

Name on Card:_____

Card #_____

Expiration date: _____ Security code: _____

OR

Name on account: _____

Account#: _____ Routing#: _____

Phone number associated with account: _____

Billing street address:_____

City: _____ State: _____ Zip:_____

Signature: _____ Date