FOR PROVIDER USE ONLY

DX:

Michael M. Takamura, M.D.
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Phone 858-592-6644 Fax 858-592-6393

PATIENT INFORMATION

FIRST NAME		MIDDLE NAME		LAST NAME	
BIRTH DATE	AGE	SEX ☐ M ☐F	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐SEPARATED ☐WIDOWED		
MAILING ADDRESS			CITY	STATE	ZIP
HOME PHONE ( )		WORK PHONE ( )		MOBILE PHONE ( )	
SOCIAL SECURITY #		EMPLOYER		PREFERRED CONTACT NUMBER ☐ HOME ☐ WORK ☐ MOBILE	
PRIMARY CARE PHYSICIAN			PHONE ( )	MAY WE CONTACT THIS PERSON? ☐ YES ☐NO	
REFERRED BY			PHONE ( )	MAY WE CONTACT THIS PERSON? ☐ YES ☐NO	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT)

FIRST NAME		MIDDLE NAME		LAST NAME	
BILLING ADDRESS			CITY	STATE	ZIP
HOME PHONE ( )		WORK PHONE ( )		MOBILE PHONE ( )	
SOCIAL SECURITY #		RELATIONSHIP TO PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER__________________			

EMERGENCY CONTACT INFORMATION

NAME		RELATIONSHIP TO PATIENT
HOME PHONE ( )	WORK PHONE ( )	MOBILE PHONE ( )

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARDS TO BE COPIED)

☐ PLEASE CHECK HERE IF YOU HAVE NO INSURANCE AND YOU WILL BE SOLELY RESPONSIBLE FOR PAYMENT.

PRIMARY INSURANCE		SECONDARY INSURANCE	
SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE	SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE
SUBSCRIBER ID #	GROUP #	SUBSCRIBER ID #	GROUP #
SUBSCRIBER EMPLOYER	RELATIONSHIP TO PATIENT ☐ SPOUSE ☐PARENT ☐OTHER____________	SUBSCRIBER EMPLOYER	RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐PARENT ☐OTHER____________

I hereby authorize my insurance companies to pay directly to Michael M. Takamura, M.D.. insurance payment otherwise payable to me for services rendered. I also authorize the doctor to release any information requested by the above named insurance companies that might be needed to process this claim.

I understand that I am financially responsible for all charges whether or not they are covered by insurance and for missed appointments and cancellations with less than 24 hours notice. In the event of default, I agree to pay all costs of collection, including collection agency fees and reasonable attorney fees, and acknowledge my account may be subject to a 1.5% monthly interest fee for delinquent charges.

I have read and understand the Office Policies and Consent for Treatment and do so agree to these conditions.

SIGNATURE____ DATE_______________

Office Policies and Consent for Treatment

I, ______________________________ (the patient), authorize and request that Michael M. Takamura, M.D. (the physician), provide evaluation and treatment services which now, or during the course of my care, are advisable. The frequency and type of treatment will be decided between my physician and me. Psychiatric evaluations last for 45-60 minutes. Follow up visits vary in length: 10-15 minutes for medication management and either 30 or 45 minutes for brief or full therapy/medication management sessions. I understand that there is every hope that I will benefit from treatment but there is no guarantee that this will occur. I recognize that modern psychiatric medication treatment includes risk of common side effects and the possibility of serious harm or even remote risk of death. I understand that maximum benefit and safety will most likely occur with consistent follow up, following recommendations, and that no treatment or a trial off medication is always a treatment option.

Payment of Fees: Payment for services is the patient's responsibility at the time of service. I agree to pay my share of charges, such as co-payments and deductible amounts at the time of each visit. I agree to notify the physician or his office during the course of treatment if problems arise regarding my ability to make timely payments or if my insurance coverage changes. 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 Michael M. Takamura, M.D.'s fees are within the usual and customary rates for medical services in the San Diego area. For specific dollar amounts, please ask the office staff. Please note that there is a $25 service fee for all returned checks and delinquent accounts (greater than 90 days) will be charged a 1.5% monthly interest fee.

Non-Clinical Services: I understand that the physician is available to provide services not related to direct patient care. These services may include disability paperwork completion, phone calls or other communications or services requested. These services are not covered by insurance and will be billed at a rate of $400 per hour in ten (10) minute increments.

Appointments: Scheduling of an appointment involves reservation of a time specifically for me. I agree to pay a $50 fee for a missed appointment or cancellation with less than 24 hours notice. I understand that insurance companies do not pay for missed appointments. The minimum visit frequency is six months to be prescribed any medications by the physician (4 months for controlled substances and 2 months for stimulants). If I have not been seen for that amount of time, I understand that refill requests will be denied until I attend an appointment with the physician.

Insurance: This office will submit insurance claims to my carrier at no cost to me. However, neither the physician nor his office is in a position to guarantee payment from my insurance company since the claim is based upon agreements between me and my insurer. It is common for insurance companies to subcontract certain benefits to another company. In these instances, the physician may not bill my insurance company, but may be required to bill my medical group or a third-party payer. I understand that it is my responsibility to know if this is true.

Managed Care Consent for Treatment: Utilizing a managed care company requires decisions about the frequency and type of treatment to be made between the patient, the physician and the managed care company. Managed care companies will sometimes only pay for limited treatment which, potentially, may not be sufficient to meet patient needs. I understand that I am responsible for any services not paid by the managed care company, including charges for missed appointments. At some point during treatment, the managed care company may decide not to pay for further services. In such a situation, I will need to decide whether to continue treatment with the physician and accept responsibility for treatment costs on a cash payment basis.

Protected Health Information: 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 healthcare clearinghouse. The protected health information relates to my past, present, or future physical health, mental health or condition and identifies me, or provides a reasonable basis to believe the information may identify me.

I understand that 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 this medical practice. The physician is not required to agree to the restrictions that I may request. However, if the physician agrees to any requested restriction, then this restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that the physician has taken action in reliance on this consent.
I understand that I have a right to review Dr. Michael M. Takamura, M.D.'s Notice of Privacy Practices prior to signing this document. This Notice of Privacy Practices is available on request of the office staff.
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 Dr. Michael M. Takamura, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by requesting it in writing or at my next appointment.

CONFIDENTIALITY: Professional ethics and California state law specifies that communications to medical staff are confidential and may not be released or shared without the expressed written permission of the patient, except as noted above or in the Notice of Privacy Practices. Disclosure may be required or permitted in the following circumstances:

1. When there is a reasonable suspicion of child abuse or abuse to a dependent or elder adult.
2. When the patient communicates a threat of bodily injury to others.
3. When the patient is suicidal.
4. Physical injury due to violence.
5. To appropriately coordinate treatment with the referral source and/or primary care physician or other medical or mental health treatment providers involved in the patient's care.

Consultation with the physician's professional colleagues uninvolved in my care may occur. In such cases, neither my name nor any identifying information will be revealed.

EMERGENCY PROCEDURES: If contact with the physician is necessary between sessions, please leave a message with the office staff or voice mail system by dialing 858-592-6644 and your call will be returned in a timely manner. If any emergency situation arises, inform the office staff or the answering service that your call is an emergency. The staff or service will make every effort to reach the physician or covering clinician. When the physician is out of town or otherwise unavailable, a qualified professional will provide coverage.

I understand that this treatment consent is an agreement between me and Dr. Michael M. Takamura, M.D., sole proprietor. Psychiatric and Behavioral Health is a collection of independent providers that share office space and certain expenses, but is not a group medical practice.

Please do not hesitate to contact the physician, the office staff, or your insurance provider if you have questions or concerns about your care and/or treatment.

I HAVE READ AND UNDERSTAND THESE OFFICE POLICIES.

____ ____________________
Patient Signature Date

Page 3 (summary of policies) was given to the patient. __________
Staff initials

TAKEAWAY POINTS FROM OFFICE POLICIES AND CONSENT FOR TREATMENT:

- Psychiatric treatment (like any medical treatment) involves potential benefits and risks
- Fees for services and copays are due at the time of service
- Missed appointments or late cancellations are charged $50
- Fees for non-clinical services (such as completing disability forms) are $65 per 10 minutes
- Minimum visit frequency is 6 months in order to be continued on any medications (4 months for controlled substances, 2 months for stimulants)
- Treatment is confidential and privacy will be protected per federal and state law
- Dr. Takamura is a solo practitioner, not part of a group practice.