SHAWN BARNES M.D.

700 GARDEN VIEW
SUITE 201-C
ENCINITAS, CA 92024

NEW PATIENT FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City, State, Zip: _____

E-mail: _____ Phone: _____

Name you prefer to be called: _____

Primary Care Doctor (if any):

Name: _____

Telephone Number: _____

Ok to contact this person? **Yes** ☐ **No** ☐

Preferred Pharmacy (if any):

Name: _____

Address: _____

Telephone Number: _____

Psychiatrist or therapist (if any):

Name: _____

Telephone Number: _____

Ok to contact this person if needed? **Yes** ☐ **No** ☐

Emergency contact:

Name: _____

Telephone Number: _____

Ok to contact this person if needed? **Yes** ☐ **No** ☐

Personal Information:

Are you married? **Yes** ☐ **No** ☐ *If so, what is your spouse's name?* _____

Do you have children? **Yes** ☐ **No** ☐ *If so, what are their names and ages?* _____

_____

What is your occupation? _____

Do you identify with any religious or spiritual affiliation? **Yes** ☐ **No** ☐

If yes, please tell me more _____

Do you exercise regularly? **Yes** ☐ **No** ☐ *If yes, please tell me more* _____

Do you follow a particular diet or philosophy of eating? **Yes** ☐ **No** ☐

If yes, please tell me more _____

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Medical and Psychiatric History:

What psychiatric conditions (if any) have you been treated for?

☐ I am not aware of any prior psychiatric conditions

Have you ever been admitted to a psychiatric hospital? **Yes** ☐ **No** ☐

If yes, please tell me more

What medical conditions do you have?

☐ I am not aware of any ongoing medical issues

What medications, herbals, or supplements you are currently taking? Please list all:

Medication or supplement	Daily dosage	Medication or supplement	Daily dosage

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Have you ever had any allergies or negative reactions to medications?

☐ I am not aware of any allergies to medications

Medication	Allergy or negative reaction

Are there any psychiatric conditions that have affected others in your family? If so, please list the condition and who was affected:

Treatment Questions / Goals:

For what problems are you seeking help?

What are your goals for treatment? What would you like to change or be different about yourself?

How satisfied are you with the support you receive from your family/friends? Select one.

Very Unsatisfied ☐ ***Unsatisfied*** ☐ ***Satisfied*** ☐ ***Very Satisfied*** ☐

How satisfied are you with your quality of life? Select one.

Very Unsatisfied ☐ ***Unsatisfied*** ☐ ***Satisfied*** ☐ ***Very Satisfied*** ☐

Is there anything else you think is important for me to know before we meet?

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Confidentiality

Information about my patients remains confidential whenever possible. This is essential to develop a trusting and open relationship, crucial for mental health treatment. When I believe that release of information would be beneficial, I will usually request written consent by an Authorization for Release of Information. However, verbal consent may be acceptable at times. I will request your permission to remain in touch with your primary care physician, and other key healthcare providers. It is your choice whether to permit such contact or not. Also, insurance companies may require a diagnosis and description of the service rendered in order to cover costs. Although patient/psychiatrist communications are generally protected as confidential under the law, there are rare circumstances in which the law may require a healthcare professional to release information about you without your authorization, such as: (1) If I have reason to believe that you pose a direct threat of imminent harm to any individual (including yourself) or (2) If I have reason to believe that abuse or neglect of a child, elder, dependent or disabled person is taking place. When information needs to be released, I will strive to protect your privacy and share only that information which is legally or medically necessary to disclose.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

I. Who is Subject to This Notice

Shawn Barnes, M.D.

II. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to maintain the privacy of your health information as required by law; Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain; Follow the terms of our Notice currently in effect.

III. Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person: Shawn Barnes, M.D. www.sbarnesmd.com

IV: Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information.

V: Other Uses and Disclosures

Required By Law: We may disclose health information about you as required by federal, state, or other applicable law.

Workers' Compensation: We may disclose health information about you for purposes related to workers' compensation, as required and authorized by law.

Any Other Use or Disclosure -- Authorization Required: Before using or disclosing your personal health information for any other purpose not identified above, we will obtain your written authorization. Unless action has already been taken in reliance on the authorization, you have a right to revoke such authorization by submitting your request in writing to us (see section III above for contact information).

VI: Psychotherapy Notes

Psychotherapy notes may be disclosed by a therapist only after you have given written authorization to do so. (Limited exceptions exist, e.g. in order for your therapist to prevent harm to yourself or others, and to report child abuse/neglect). You cannot be required to authorize the release of your psychotherapy notes in order to obtain health-insurance benefits for your treatment, or enroll in a health plan. Psychotherapy notes are also not among the records that you may request to review or copy (see discussion of your rights in section VII below). If you have any questions, feel free to discuss this subject with Dr. Barnes

VII: Your Health Information Rights

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

-Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.

Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.

-Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.

-Request that we amend the health information about you that is maintained in our files. Your request must explain why you believe our records about you are incorrect require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.

-Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge. However, if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested. We will be unable to provide you an accounting for any disclosures made before April 14, 2003, or for a period of longer than six years

-Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section III above for information). If you have questions about your rights, please speak with Dr. Barnes, available in person or by phone or email, during normal office hours.

VIII: To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to Dr. Barnes (see section III above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-(800) 368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint

IX: Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area(s) of our office, and make copies available to our patients and others.

X: Effective Date: 11/15/2017

I have reviewed this notice

I hereby consent to psychiatric treatment with Shawn Barnes, MD. I am aware of my right to ask questions about my treatment, diagnosis, and other aspects of care.

Signature _____ Date _____

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Policy for Phone/Email Communication

Phone and email communication is not intended for emergencies. Please keep in mind that the goal is to return calls or emails by the end of the next business day, but this is not always guaranteed. Dr. Barnes is not available by phone or email on nights and weekends. Dr. Barnes is also not available by text.

If you are experiencing a psychiatric emergency, please either call the San Diego Crisis Line at 1-888-724-7240 or go directly to the nearest hospital emergency room.

I acknowledge that I have read and agree to the policy on phone/email correspondence. I hereby consent to have email correspondence with Dr. Barnes, if necessary.

Signature _____ Date _____

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Telepsychiatry Consent Form

Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as Zoom, when the psychiatrist and the patient are not at the same location. Telepsychiatry allows the patient to receive psychiatric care without the need to visit the office. Potential risks include, but are not limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face-to-face visit may result in errors in medical judgment. Alternatives to telepsychiatry include traditional face-to-face sessions.

Your Rights:
1) I understand the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
2) I understand Zoom is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protection against intentional or unintentional corruption.
3) I have the right to withdraw my consent for the use of telepsychiatry during the course of my care at any time.
4) I understand Dr. Barnes has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time.
5) I understand all rules and regulations which apply to the practice of psychiatry in the State of California also apply to telepsychiatry.

Your Responsibilities:
1) I will not record any telepsychiatry sessions without the prior written consent of Dr. Barnes and I understand Dr. Barnes will not record telepsychiatry sessions without my consent.
2) I will inform Dr. Barnes if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Barnes will inform me if any other person can hear or see any part of the session before the session begins.
3) I understand I must be a resident of California and physically located in California to be eligible for telepsychiatry services from Dr. Barnes.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize the use of telepsychiatry by Dr. Barnes in the course of diagnosis and treatment.

Patient Name (print): _____ **Date of Birth**: _____

Signature: _____ **Date**: _____

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Policy for Payment and Cancellation

- Payment can be made by either cash or credit card. Dr. Barnes will keep your credit card information on file for future payments.
- There is no charge for cancelling an appointment if at least 24-hour notice is given. However, if less than 24-hour notice is given, Dr. Barnes will charge the scheduled fee for that appointment. If you arrive late to an appointment, the original fee for that appointment will be maintained.
- Any significant additional time requested outside of scheduled appointments will be billed in 15-minute increments. This includes filling out forms, writing letters, review of outside records, or other administrative tasks.

I acknowledge that I have read and agree to the policy on payment and cancellation.

Signature _____ Date _____

Credit Card Authorization

Dr. Barnes will keep your credit card information securely on file and charge for our visits. Please fill in your credit card information below.

I, _____, am authorizing Shawn Barnes, MD to charge my credit card for any services rendered as agreed above. I also authorize Shawn Barnes, MD to charge my card consistent with the Cancellation/Late Policy. I acknowledge that I have read and fully understand the Cancellation Policy. Furthermore, for outstanding payments of services rendered, I authorize Shawn Barnes, MD to charge my credit card for the full amount due. I further authorize Shawn Barnes, MD to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card #: _____ Expiration Date: _____

CID (# on back of card): _____

Name as Printed on Card: _____

Signature _____ Date _____