Integrated Behavioral Health & Medicine
Comprehensive Neurobehavioral Specialists

Today's Date: | Who is submitting Information: | Reffered By: | Their Phone:

Name/Address/Demographics

First Name: | Last Name: | Name you like to be called:

Street: | City: | State: | Zip:

Home Phone: | Cell Phone: | Work Phone:

Email:

Best way to leave message: ☐ Home ☐ Cell ☐ Work

Would you like to be on CNS Mailing List?: ◯ No ◯ Yes

BirthDate:(mm/dd/yyyy) | Age: | SS#: | Driver's Lic#:

Family and/or friends to be contacted in an emergency:

Name: | Phone:

Current Concerns:

Please provide a brief description of the major concerns that lead you to seek treatment:

Previous Psychiatric or Psychological History:

Name of clinician: | Phone number:

Your experience with previous treatment: ☐ Positive ☐ Neutral ☐ Limited ☐ Negative

Have you been hospitalized for psychiatric or substance abuse problems? ◯ No ◯ Yes #: time, year(s):

Please indicate any major illnesses or hospitalizations:

Health/Substance:

Do you smoke? ◯ No ◯ Yes, _____ per day

Do you drink alcohol? ◯ No ◯ Yes, # drinks _____ per week

Any other recreational drug use? ◯ No ◯ Yes, explain _____ per week

Do you exercise? ☐ Regularly ☐ Occasionally ☐ Rarely ☐ Never

How is your general food diet? ☐ Very healthy ☐ Questionably healthy ☐ Not very healthy

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Social/Family/Occupational:

Gender: ◯ Male ◯ Female Ethnicity: _____ Relationship Status: _____

Children? ◯ Yes ages, _____ ◯ No

Occupation: _____ Currently Employed?: ◯ Yes ◯ No,last _____ yrs ago

Student?: ◯ Yes ◯ No , school name: _____

Education:

_____

(highest level of education, degree, major/specialization)

Please describe your family relationships:

_____

How is your social network? ☐ No close friends ☐ One close friend ☐ Few friends ☐ Many friends

How often do you make contact with friends? ☐ Regularly ☐ Occasionally ☐ Infrequently ☐ Never

Are you currently in a romantic relationship ◉ No ◯ Yes, it is... ☐ Generally positive ☐ Neutral ☐ Problematic

Are you able to talk to others about the concerns that bring you into therapy? ◉ No ◯ Yes

What is your living situation? ◯ Live alone ◯ Live with others, whom _____

How do you feel about your (circle either or both) work/school:
☐ Pleased ☐ Mostly satisfied ☐ Mixed ☐ Mostly dissatisfied ☐ Unhappy

Major dissatisfactions with work or school(circle either or both):

_____

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CNS Fees

Psychiatric (M.D./N.P.)	• New Evaluations: $695 / 2 clinical hours* • Follow-up Appointments: $450/clinical hour* • May see psychiatrist (M.D.) and/or accompanying Nurse/Practitioner (R.N./N.P.) • Clinical hour definition, please see below*
Psychologist (Ph.D.)	• $250 / clinical hour*
Psychotherapy (MFT)	• $175 / clinical hour*
Extended Appointments	• Fees will be pro-rated for any appointments beyond a "clinical hour." (definition, below),
Case Coordinator, Educational Therapy, Exercise Physiologist	• $175 / hour • Appointments may not necessarily be face-to-face time with patients, but may also include administrative time with staff, outside providers, and travel time.
Private Nursing Shifts	• Nursing (RN) $125/ hour, Nurse Practitioner $175/ hour • Nursing shifts are billed in at least four (4) hour increments.
CNS Treatment Team Meetings	• Billed as the aggregate of all clinicians present.
Neuropsychological Testing, Neuroimaging Analysis	• Fees available upon request.
TMS (Transcranial Magnetic Stimulation)	• Fees available upon request.
IV Ketamine Infusion	• Fees available upon request.

CNS Policies

***Clinical Hour Definition**	• A “clinical hour” consists of 15 minutes of non-patient documentation time (e.g. the time spent directly with the patient is typically 45 minutes). A “clinical half hour” consists of 7.5 minutes of non-patient documentation time. For appointments beyond a clinical hour (which is 45 mins directly with the patient), fees will be pro-rated commensurately.
Overtime Fees	• For services rendered outside regular business hours (9am-6pm), or occurring on weekends or nationally-observed holidays are charged 150% of usual rates.
Payment	• Payment is due at the time of service. Once service has been rendered, fees are not refundable. CNS does not guarantee any outcome or satisfaction. Phone appointments are charged the same rates as office appointments. The only form of payment accepted by CNS is credit card.
Medication Refills	• Paper prescriptions are only provided in the office during appointments. Prescriptions are not called in over the telephone, except in the case of emergency.
Invoices & Insurance	• CNS is an “Out-of-Network” provider. We do not process payments from health insurance. Upon charging, we will email you an invoice with all necessary claim codes for your insurance company. If you submit them, they will reimburse you directly, as their policy allows. Our invoices contain sensitive information revealing your diagnoses codes. In order to protect your confidentiality, CNS will not disclose any other information to your health insurance carrier. Please note that each psychiatric appointment is split into 2 entries (each being 1/2 of the total fee). This is because of national billing code standards from insurance companies which require us to do so.
Cancellation Policy	• Please inform us at least 48 business hours in advance if you need to change or cancel an appointment. Otherwise, the usual fees and payment is required.

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Credit Card Authorization

It is a policy of CNS that this Credit Card Authorization be completed in order to schedule your first appointment. This credit card will be used for payment of all services.

This authorization form shall serve as a legally binding contract that provides you with important information regarding the financial practices of Comprehensive Neurobehavioral Specialists. By signing below you acknowledge that you are financially responsible for the fees for rendered services according to this contract, and that you have read and understand the above information and agree to comply with the above policies. Any questions or concerns regarding the contents of this agreement should be discussed with us prior to signing.

You hereby authorize Comprehensive Neurobehavioral Specialiststo charge your credit card in the event that you fail to show for an appointment or fail to provide advance notice as indicated above and agreed to in this form. Furthermore, for outstanding payments of services rendered, you authorize Comprehensive Neurobehavioral Specialiststo charge your credit card for the full amount due. You will not dispute charges for sessions which have been rendered nor which have been canceled outside of the cancellation policies listed above. You further authorize Comprehensive Neurobehavioral Specialiststo disclose information about your attendance/cancellation to your credit card company if a dispute occurs. This form will be stored in your clinical file and may be updated at any time.

Important: Please note that all CNS invoices are sent via email to the email address of the credit card holder. We do not use regular mail unless specifically requested. These contain sensitive information which include diagnostic and appointment codes.

General Information

Name of Patient:

Name of Financially Responsible Party:

Relationship to patient:

Credit Card Information

Credit Card type: Visa MasterCard Discover Amex

Name as on card:

Phone Number of Cardholder:

Email of Cardholder:

Billing Address:

Street:

City, State & Zip:

Card #: Confirm Card #:

Expiration Date:(mm/yyyy)

Security Code (3-digit code on back by signature line):

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Do you currently receive regular medical or psychiatric care from a physician or clinic? ◯ Yes ◯ No

Name of Physician or Clinic:

Phone:

Have you ever received any of the following diagnoses?

- ☐ Anxiety Disorder or Phobia
- ☐ Obsessive Compulsive Disorder
- ☐ Epilepsy or Convulsions
- ☐ Suicide or Suicide Attempt
- ☐ Thyroid Problem
- ☐ Psychiatric Hospitalization
- ☐ Tourette's disease
- ☐ Parkinson's disease
- ☐ Bipolar disorder
- ☐ Schizophrenia or psychosis
- ☐ Nervous Breakdown
- ☐ Drug Abuse
- ☐ Attention Deficit Disorder
- ☐ Panic attacks
- ☐ Huntington's disease
- ☐ Porphyria
- ☐ Depression
- ☐ Heart Attack/trouble
- ☐ Alcoholism
- ☐ Migraine Headaches
- ☐ Alzheimer's disease
- ☐ Autism
- ☐ Wilson's disease
- ☐ Anorexia or Bulimia

List any current medications& dose:

List any allergies:

List any current or past major medical conditions:

Most recent physical exam and blood tests:

Recent: labs/tests:	Date(mm/dd/yyyy)	Result
Blood Tests:		
Chest X-Ray:		
TB Skin Test (PPD):		
Electrocardiogram (EKG):		
Brain Scan or MRI:		
EEG:		

Have you ever had any of the following injuries or conditions?

- [ ] Head Injury
- [ ] Concussion
- [ ] Knocked Unconscious
- [ ] High Blood Pressure
- [ ] Diabetes
- [ ] Cancer
- [ ] Thyroid Disease
- [ ] Alcoholism
- [ ] Heart Disease
- [ ] Glaucoma
- [ ] Epilepsy
- [ ] Migraine Headaches
- [ ] Stomach ulcers
- [ ] Colitis
- [ ] Irritable Bowel
- [ ] Tuberculosis
- [ ] Stroke
- [ ] Rheumatic Fever
- [ ] Asthma
- [ ] Food/chemical poisoning
- [ ] Birth Defects
- [ ] Severe Cuts
- [ ] Broken Bone
- [ ] Hepatitis
- [ ] Kidney disease/stones
- [ ] Blood transfusions
- [ ] Lyme disease

Current height:

Current weight:

Most you've ever weighed?

When?

Any recent weight loss or gain? [ ] Yes

Have you ever had to be hospitalized or had surgery? If yes, please explain with detail:

Use any of the following? If so, amount currently using & most ever used:

Coffee (cups/day):

Cigarettes (packs/day):

Alcohol (amounts and types of alcohol used daily):

Marijuana (joints/day):

Cocaine, heroin, other drugs:

Vitamins, herbs:

Sleeping Pills:

Aspirin:

Laxatives or Diuretics:

For females only:

Date your last menstruation began:(mm/dd/yyyy)

Number of pregnancies:

Number of children born alive:

Number of abortions:

Number of miscarriages or stillbirths:

Pap smear within the last year? Yes No

Do you use any contraceptive method? Yes No If yes, what

Review of your current health:

Do you now or in the past have?

- Lumps anywhere
- Double vision or poor vision
- Difficulty hearing
- Fainting spells, blackout spells
- Convulsion
- Paralysis
- Dizziness
- Headaches
- Thyroid problem
- Skin problem
- Cough or wheeze
- Excessive thirst
- Urine problems, blood in urine
- Indigestion, gas, heartburn
- Stomach pain/ulcer
- Diarrhea
- Constipation
- Vomiting
- Blood in stool
- Change in appetite or eating habits
- Trouble sleeping
- Sexual problems
- Spitting up blood
- Chest pain
- Shortness of breath
- Palpitation/heart fluttering
- Swelling of hands/feet
- Visual hallucinations
- Depression
- Suicidal thoughts
- Weight loss or weight gain
- Problems w/memory, thinking or concentration
- Weakness or tiredness
- Joint pain
- Snoring
- Jerk your arms/legs while asleep
- Wet the bed
- Gasping breath during sleep
- Have crawling leg sensations
- Fall asleep suddenly during the day
- Walk or talk in your sleep
- Binged on food uncontrollably
- Forced yourself to vomit food
- Used laxatives, diet pills, enemas
- Stopped having your menstrual period
- Been told you are bulimic or anorexic
- Repetitive, unwanted thoughts
- Irresistible urges to do things repeatedly
- Twitches, tics
- Hearing voices when no one is around
- A feeling of unreality
- Watching things disappear, or change shape, color or position when this should not have occurred
- Unusual (rotten or fragrant) smells without anything to account for it
- Feelings of being touched without anyone or anything actually touching you
- A sense of detachment from your surroundings
- Finding yourself in a place and having no idea how you got there
- Minutes, hours or days having gone by without any memory of what has happened during that time
- Having no memory for some important event in your life (for example, a graduation, wedding, death)

While in school or work, did you:

- Have trouble sitting still in class
- Have trouble concentrating on school work
- Have trouble getting along with schoolmates
- Have anxiety about going to school
- Get left back or expelled
- Attend special education classes
- Have stutter, lisp
- Run away from home

Have you ever been:

- [ ] In the military
- [ ] Arrested for any reason
- [ ] Injured in an accident or war
- [ ] Subject to any sort of abuse
- [ ] Involved in a lawsuit
- [ ] Exposed to toxic chemicals

Do you ever have irresistible urges to:

- [ ] Hurt, attack or kill someone
- [ ] Throw, break, destroy property
- [ ] Steal objects you don't need
- [ ] Gamble
- [ ] Deliberately set fires
- [ ] Deliberately pull your hair out

Recent stressful life events (in last 2 years):

- [ ] Marriage or engagement
- [ ] Separation or divorce
- [ ] Breakup of relationship
- [ ] Extreme relationship difficulties
- [ ] Death of close family, friend
- [ ] Child left home
- [ ] Bad health of family, friend
- [ ] Personal injury or illness
- [ ] Sexual difficulties
- [ ] Changes in school, work
- [ ] Changes in residence
- [ ] Financial difficulties
- [ ] Legal difficulties

Family History:

Age of biological: Father | Mother | Sisters | Brothers | Children

Any of them deceased?

Has anyone in your family had any of the following:

- [ ] Anxiety Disorder or Phobia
- [ ] Psychosis or Schizophrenia
- [ ] Depression
- [ ] Obsessive Compulsive Disorder
- [ ] Bipolar disorder
- [ ] Heart Attack/trouble
- [ ] Epilepsy or Convulsions
- [ ] Nervous Breakdown
- [ ] Alcoholism
- [ ] Suicide or Suicide Attempt
- [ ] Drug Abuse
- [ ] Migraine Headaches
- [ ] Thyroid Problem
- [ ] Attention Deficit Disorder
- [ ] Alzheimer's disease
- [ ] Psychiatric Hospitalization
- [ ] Panic attacks
- [ ] Autism
- [ ] Tourette's disease
- [ ] Huntington's disease
- [ ] Wilson's disease
- [ ] Parkinson's disease
- [ ] Porphyria
- [ ] Anorexia or Bulimia

Have you ever been abused in any way?

- [ ] Physical
- [ ] Sexual
- [ ] Emotional

If so, what effects have occurred in your life due to this experience?

Legal History:

Are you presently suing anyone or thinking of suing anyone? ◯ Yes ◯ No

If yes, please elaborate:

Is your reason for coming to CNS related to an accident, injury, or court-related?
If yes, please elaborate:

Have you had psychological or educational testing? ◯ Yes ◯ No

Name of tester:

Phone Number of tester:

Year of Testing:

Have you ever taken any of the following medications?

- ☐ None of the following
- ☐ Lexapro (escitalopram)
- ☐ Celexa (citalopram)
- ☐ Prozac (fluoxetine)
- ☐ Zoloft (sertraline)
- ☐ Paxil (paroxetine)
- ☐ Wellbutrin (bupropion)
- ☐ Remeron (mirtazapine)
- ☐ Effexor (venlafaxine)
- ☐ Cymbalta (duloxetine)
- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzipine)
- ☐ Risperdal (risperidone)
- ☐ Abilify (aripripazole)
- ☐ Geodon (ziprasidone)
- ☐ Clozapine (clozaril)
- ☐ Cytomel
- ☐ Buspar (buspirone)
- ☐ Neurontin
- ☐ Lyrica
- ☐ Lithium
- ☐ Lamictal (lamotrigine)
- ☐ Tegretol (carbamazepine)
- ☐ Depakote (valproic acid)
- ☐ Xanax (alprazolam)
- ☐ Klonopin (clonazepam)
- ☐ Ativan (lorazepam)
- ☐ Restoril (temazepam)
- ☐ Ambien
- ☐ Sonata
- ☐ Rozerem
- ☐ Ritalin
- ☐ Concerta
- ☐ Dexedrine
- ☐ Focalin
- ☐ Adderall
- ☐ Provigil
- ☐ Nuvigil
- ☐ Anafranil (clomipramine)
- ☐ Norpramin (desipramine)
- ☐ Pamelor (nortriptyline)
- ☐ Parnate
- ☐ Marplan
- ☐ Nardil

If yes to any of the above, which were helpful and what was your dose?

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

CNS Integrated Behavioral Health is dedicated to maintaining the privacy of your personal health information as part of providing professional care. CNS is also required by law to keep your information private. These laws are complicated, but we must give you this important information. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

CNS will use the information we collect about you MAINLY to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use, send, share, or release your information for other purposes,we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work regarding treatment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

CNS will be happy to discuss these situations with you now or as they arise.
If you have any questions regarding this notice or our health information privacy policies, please contact us.

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CONSENT FOR SERVICES

This letter of agreement confirms that CNS has been asked by you to provide mental health services.

General Policies

General	We intend to help you feel and function significantly better. There is an expectation, but no guarantee, that you will benefit from treatment. In order for your treatment to be effective, we must work cooperatively. Try to talk as freely as you can about the difficulties that are affecting you and try to approach the session as open-mindedly as possible.
Confidentiality	What is discussed during appointments will not be revealed to anyone outside of CNS without your permission except where disclosure is required by law, such as if there is concern for 1) abuse or neglect of a child, dependent, or elder adult, 2) danger of harm to yourself or others, 3) grave disability to one's functioning or survival, or 4) pursuant to legal proceedings. I may ask you to sign a "Release of Information" to coordinate care with other health care professionals of yours. Your information will not be disclosed to your health insurance carrier without prior written consent.Please note that this agreement authorizes clinicians of CNS to discuss your confidential information internally with the other staff of CNS.
Risks and Benefits	Medications and psychotherapy each have risks and benefits. Risks of medication will be discussed in appointments before starting new prescriptions. Risks of psychotherapy include experiencing uncomfortable levels of emotion. In the worst case scenario, risks of psychotherapy may include temporary worsening of psychiatric symptoms. Treatment often requires recalling unpleasant aspects of your history as well as the experience of emotional pain in the present. Medications as well as psychotherapy have been shown to have benefits for people who undertake them, often leading to a significant reduction of feelings of distress, reduction of symptoms, better relationships, and resolutions of specific problems.
Limits of Service	In the event of a medical emergency, call 911 or go to an emergency room immediately. Call CNS as soon as is practical and possible. CNS does not provideinsurance, disability, or workman's compensation evaluations. In the event that you intend to apply for medical or life insurance or file a claim for disability orworkman's compensation while under the care of CNS, please discuss this first with your clinician because authorization must be provided by your clinician as well as CNS.
Nature of Practice	CNS Health is a California Medical Corporation. Alternative names include CNS, CNS Los Angeles, and CNS Integrated Behavioral Health.

Office Policies

Cancellation Policy	The scheduling of an appointment involves the reservation of a clinician's time specifically for you. If you need to cancel or change an appointment, please inform us at least48 business hours in advance, otherwise you will still be billed and payment is required.For Nursing shifts, cancellation must occur 5 business days in advance, or you will be billed.
Reaching Us	Clinicians or staff at CNS try to answer calls live or return routine phone calls within one business day.Although you may feel free to email CNS, we do not routinely use email for professional communication. Important information should be conveyed to us in person, ideally in appointments.
Records	CNS keepsconfidential records of your treatment that include appointment times,

billing records, indications for medication use and response, and certain content of the appointments. You, or a future treating clinician, can request copies of your medical record. Copies for patients are assessed fees which are average for the community. Psychotherapy notes belong to CNS and are not a part of the medical record, therefore they cannot be requested to be viewed. Clinicians at CNS do not give testimony in court. In the unfortunate circumstance that you sue CNS, you thereby waive your confidentiality and CNS is allowed to present your records without your consent.

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I Agree to the Terms & Conditions In CNS Agreement | Print