Telehealth location-CA

1225 Cypress Ave Street 3 Los Angeles, California 90065
info@kelhealthandwellness.com

PATIENT INTAKE INFORMATION

CONTACT INFORMATION

Everything in BOLD must be filled-in (with blue or black ink ONLY)

PATIENT NAME: _____ **BIRTHDATE:** _____

SEX: ☐ MALE ☐ FEMALE ☐_____ SOCIAL SECURITY NO: _____

HOME PHONE: _____ **CELL:**_____

HOME ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMAIL: _____

REFERRED BY: _____

EMERGENCY CONTACT: _____ **RELATION:** _____ **PHONE:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

POLICY/ID NUMBER: _____ **GROUP NUMBER**: _____

SUBSCRIBER'S NAME: _____ **BIRTHDATE:** _____

RELATION TO PATIENT: _____ **SS#**: _____

SECONDARY INSURANCE ***(Include any Medi-Cal plans)***: _____

POLICY/ID NUMBER: _____ **GROUP NUMBER**: _____

SUBSCRIBER'S NAME: _____ **BIRTHDATE:** _____

RELATION TO PATIENT: _____ **SS#**: _____

AS PATIENT, OR AS LEGAL GUARDIAN OF MINOR PATIENT, I AGREE TO PAY FOR ALL SERVICES RENDERED. THIS OFFICE MAY BILL MY INSURANCE CARRIER AS NEEDED. I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES. I AUTHORIZE THIS OFFICE TO RELEASE MY INFORMATION TO PROCESS ANY REQUESTS.

❑ For patients under 18 years of age: *I CERTIFY THAT I HAVE LEGAL GUARDIANSHIP OF THE PATIENT AND I AM AUTHORIZED TO MAKE HEALTHCARE DECISIONS FOR THE PATIENT.*

SIGNATURE: _____ **DATE:** _____

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I HEREBY AUTHORIZE KEL HEALTH AND WELLNESS CENTER, INC. DBA KEL HEALTH AND WELLNESS CENTER TO RELEASE ALL MEDICAL INFORMATION TO THE ABOVE-NAMED INSURANCE CARRIER OR TO A DESIGNATED ATTORNEY FOR THE PURPOSE OF CLAIMS ADMINISTRATION AND EVALUATION UTILIZATION REVIEW AND FINANCIAL AUDIT. THIS AUTHORIZATION REMAINS VALID AND EFFECTIVE FROM THE DATE OF SIGNING UNTIL REVOKED IN WRITING.

I UNDERSTAND THAT I MAY REQUEST A COPY OF THE AUTHORIZATION.

I READ THIS AUTHORIZATION AND UNDERSTAND IT.

I HEREBY ASSIGN TO KEL HEALTH AND WELLNESS CENTER, INC. ALL MONEY TO WHICH I AM ENTITLED TO FOR MEDICAL AND/OR EXPENSES RELATIVE TO THE SERVICES RENDERED BY KEL HEALTH AND WELLNESS CENTER, INC, BUT NOT TO EXTEND MY INDEBTEDNESS TO SAID PHYSICIAN AND/OR SURGEON.

IT IS UNDERSTOOD THAT ANY MONEY RECEIVED FROM THE ABOVE-NAMED INSURANCE COMPANY OVER AND ABOVE MY INDEBTEDNESS WILL BE ASSESSED TO MY ACCOUNT.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE TO KEL HEALTH AND WELLNESS CENTER, INC. FOR CHARGES NOT COVERED BY THIS AGREEMENT.

I FURTHER AGREE IN THE EVENT OF NON-PAYMENT TO BEAR THE COST OF COLLECTIONS AND/OR COURT COST AND REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.

SIGNATURE: _____ DATE: _____

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TREATMENT CONSENT

I, _____authorize and request that KEL HEALTH AND WELLNESS CENTER, INC provides treatment which is advisable in the course of my care as a patient. The frequency and type of treatment will be decided between my provider and me.

I understand that if any medication is prescribed during the course of my treatment that any risk and side effects will be explained to me at the time and that I may request to stop medication at any time. I agree to discuss the decision to discontinue medication and the possible side effects that may occur from this decision with my provider before acting upon this decision.

I understand that maximum benefit will occur with consistent attendance and compliance with treatment (medications. counseling, etc.) as suggested by my provider, but no guarantee of the results of treatment may be expected.

Important Information to Patients

Please be advised that some providers within this practice utilize a remote scribe. A remote scribe will listen to and confidentially document your office visit from another secure location. This allows your provider to focus his/her attention on you. If you have any questions about how this process works, please ask staff at the time of scheduling.

Please be advised that we **do not** provide evaluations (diagnoses) or treatments for litigation purposes. Litigation purposes would include criminal cases, divorce, personal injury and emotional distress types of cases, among others. If you are seeking evaluation and treatment for a litigation purpose, we recommend that you retain a physician and/or psychologist who perform such legal evaluations and treatment.

The providers of the KEL HEALTH AND WELLNESS CENTER, INC **do not** provide litigation evaluations or treatments; our purpose is strictly to assist you.

I have read and fully understand this Treatment Consent form.

SIGNATURE: _____ DATE: _____

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PRACTICE GUIDELINES

The following is a list of guidelines that will allow for efficient use of your time and that of the practice's time. Please authorize the specific practices by **initialing** in the spaces provided and signing below.

1. _____ I give permission to KEL HEALTH AND WELLNESS CENTER, INC to remind me by telephone/ text/ email of my appointments. This permission extends to allowing KHWC to leave a reminder of my appointment on my message machine or voicemail.

2. _____ I give permission for the provider to use my first name in the waiting room when calling me back for my session.

3. _____ I give permission to fax any essential information to my primary physician, pharmacy, HMO, insurance provider, hospital, and/or other medical provider involved in my treatment (i.e. faxing a refill authorization to your pharmacy).

4. _____ I understand that if I am more than **7 minutes late** to an appointment the appointment will be cancelled and a **No-Show Fee** will be charged to my account, at the provider's discretion.

5. _____ I understand that any no-show fees must be paid in full prior to being eligible to reschedule a future appointment.

6. _____ I understand that if the patient is a minor (under 18 years of age), a parent, guardian or authorized person must accompany them to the appointment.

7. _____ I understand that all paperwork requested from my provider such as but not limited to, letters, FMLA paperwork and unemployment paperwork have fees associated with them and must be paid at the time of request.

8. _____ I understand that some providers at KEL HEALTH AND WELLNESS CENTER, INC utilize a remote scribe service. From a secure location, the scribe assists my provider in transcribing my appointment notes. By initialing above, I consent for this scribe to be in attendance remotely during my session.

SIGNATURE: _____ **DATE:** _____

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APPOINTMENT GUIDELINES

INITIALS AND A SIGNATURE SIGNIFIES AN UNDERSTANDING AND AGREEMENT TO THE FOLLOWING:

_____ It is my responsibility to notify KEL HEALTH AND WELLNESS CENTER, INC 24 hours prior to the scheduled appointment if I intend to cancel or reschedule that appointment. We do not accept cancellations through our answering service.

_____ I will be billed for all missed appointments, late cancellations, and late rescheduled appointments at the standard office rate of $50.00 (30-45 min. scheduled new evaluations), $50.00 (4560 min. scheduled follow-ups), or $35.00 (15-30 min. scheduled follow-ups). Any missed appointments, late cancellations, and late rescheduled appointments for psychological/neuropsychological testing, two hours in length, will be charged a standard office rate of $100.00.

_____ I agree to pay the above stated amount in the event that I miss an appointment or fail to cancel or reschedule 24 hours prior to the scheduled appointment.

_____ Payment of these above-mentioned fees is required before another appointment can be made.

_____ I understand that **two consecutive no-shows or three no-shows in a year** is considered to be "non-compliance with appointments" and will result in being discharged from services.

_____ I understand that if I have not been seen in 6 months that no refills will be given, and I will have to schedule a new patient appointment.

SIGNATURE: _____ DATE: _____

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TELEHEALTH APPOINTMENT AGREEMENT

INITIALS AND A SIGNATURE SIGNIFIES AN UNDERSTANDING AND AGREEMENT TO THE FOLLOWING:

_____ I agree to provide the KEL HEALTH AND WELLNESS CENTER, INC with an active phone number and/or email address for my telehealth appointments. I understand that it is my responsibility to inform my providers office if there has been a change to either of the aforementioned.

_____ It is my responsibility to log into my telehealth appointment at the agreed upon scheduled appointment time using the link provided to me by the KEL HEALTH AND WELLNESS CENTER, INC.

_____ I agree that my telehealth appointment will be treated in the same manner as an in-person appointment and I must provide a 24-hour notice for any and all cancellations.

_____ I understand that it is my responsibility to notify my physician's office in the event that my telehealth appointment link was not received prior to my appointment time.

_____ I understand that any telehealth appointment attempted while driving, shopping, working, or otherwise distracted, will result in an appointment cancellation and a no-show fee being applied to my account.

_____ I agree that it is my responsibility to be in a setting with access to secure WIFI and/or Internet connection and that background noise or disturbances be kept to a minimum throughout my telehealth appointment.

_____ I understand that by agreeing to conduct my telehealth appointment in the same manner as an in-person appointment, I must maintain professional rapport with my physician, by being in an appropriate setting and/or state. (i.e., appropriate dress, presentation, etc.)

_____ I agree that I will pay any insurance co-payments and/or self-pay fees to the KEL HEALTH AND WELLNESS CENTER, INCprior to my scheduled appointment time.

By my initials above, I agree to the terms set forth in this telehealth contract. I understand that if the agreed upon terms are not followed, it may result in my being discharged from KEL HEALTH AND WELLNESS CENTER, INC Center's services.

SIGNATURE: _____ DATE: _____

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Medication Compliance Contract

Patient Name: _____ **Date of Birth**: _____

I, the undersigned, agree to be in compliance to all medication management appointments and treatment plans with KEL HEALTH AND WELLNESS CENTER, INC*. I understand that my physician is requiring me to return as medically needed for these appointments (per his or her discretion).*

1. I will take my medication as prescribed by my doctor; I will talk with my doctor before changing dosage.
2. I will not accept the same prescriptions from any other doctors.
3. I will take care of my medications. My doctor will only replace lost, stolen or damaged prescriptions at his/her discretion, and I will be charged a $15 refill fee.
4. My doctor will only approve early refills at his/her discretion, and I will be charged a $15 refill fee.
5. My doctor will **NOT** approve refills when the doctor's office is closed.
6. I will request all refills by calling my pharmacy and requesting that they fax the request to the facility during doctor's office hours at least 5 days prior to taking my last dosage of medication.
7. I know that my doctor may change or stop my medication if it does not relieve my symptoms.
8. I understand that if I miss my scheduled appointment, I **MUST** make a follow up appointment and my medications will only be refilled up to that date, and I will be charged a $15 refill fee.
9. I understand that I will be required to be seen at least every 3 months to continue services.
10. I understand that controlled medications will **NOT** be filled following an appointment considered to be a no-show.

I understand that if this contract is broken at any time or if my physician feels that I am abusing any prescription medications, services with KEL HEALTH AND WELLNESS CENTER, INC will be discontinued immediately and a referral to another facility will be given along with a final 30 day supply of medications.

*I agree to **ALL** the above compliances within this contract with KHWC.

SIGNATURE: _____ **DATE:** _____

Telehealth location-CA

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info@kelhealthandwellness.com

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices of KEL HEALTH AND WELLNESS CENTER, INC.*** Our ***Notice of Privacy*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by writing to KEL HEALTH AND WELLNESS CENTER, INC1225 Cypress Ave Street 3 Los Angeles, California 90065.

I acknowledge receipt of the ***Notice of Privacy Practices of KEL HEALTH AND WELLNESS CENTER, INC.***

SIGNATURE: _____ DATE: _____

Telehealth location-CA

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization. This authorization expires **1 year** after the date it's signed, unless otherwise specified: _____ **(*Expiration date)***

Name of patient:_____ **Date of birth**: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize ***KEL HEALTH AND WELLNESS CENTER, INC*** (**KEL HEALTH AND WELLNESS CENTER, INC)*

☐ To SEND records TO: _____
Person/Organization authorized to receive the information

_____
Address - street city state zip code Phone

☐ To RECEIVE records FROM: _____
Person/Organization authorized to receive the information

_____
Address - street city state zip code Phone

Include the following information:

☐ **ALL** health information pertaining to my medical history, mental or physical condition and treatment:

☐ **OR** Only the following records or types of health information (including any specific date ranges):

_____

_____

I specifically authorize release of the following information (check as appropriate):

Mental Health treatment information _____ ***(Initial here)***

HIV test results _____ (*Initial here)*

Alcohol/drug treatment information _____ (*Initial here)*

SIGNATURE: _____ DATE: _____

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**A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.*

PURPOSE

Purpose of requested use or disclosure: ☐ Patient request; OR ☐ Other:

_____

_____

Limitations, if any:

_____

_____

MY RIGHTS

*I may inspect or obtain a copy of the health information that I am disclosing by signing this form.

*I have a right to receive a copy of this authorization.

*I may revoke this authorization at any time, but I must do so in writing and submit it to one of the following addresses:

1225 Cypress Ave Street 3 Los Angeles, California 90065

*Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE: _____ DATE: _____

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PATIENT CONTACT INFORMATION

_____

Patient Name *Date of birth* *Patient Telephone Number*

_____

Patient Address *City* *State* *Zip Code*

*If signed by other than patient, indicate authority*_____

Coordination of Care Form

With your permission, this information will be forwarded to your healthcare provider.

Practitioner/Provider Information		**Patient Information**
Provider Name:		**Patient Name:**
Phone:	**Fax:**	**Patient Date of Birth:**
Patient's Release of Personal Health Information (PHI)		
From: KEL HEALTH AND WELLNESS CENTER, INC		**To (Provider Name)**
Expiration: I understand that I may cancel this authorization at any time by sending my healthcare provider(s) my cancellation notices in writing. I understand that my healthcare provider(s) may have already released records according to this authorization, prior to receiving my written notice to cancel. Unless cancelled, this authorization expires on (date)_____.		
If Member Does Not Authorize Release of PHI - *You are not required to share this information.		
____ I **do not** authorize information about my physical and/or behavioral health treatment to be released.		
Member's Signature		Date of Member's Signature
Please check this box **if** the reason you are not releasing information is because you do not have a primary care provider: ☐		

SIGNATURE: _____ DATE: _____

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Information to Be Released		
The only information this Coordination of Care Form authorizes for release is this one-page Notification of Treatment, including the information below. *No additional records will be released without a signed Authorization for Release.		
Healthcare Coordination Information	**Medications**	**Dosages**
Treatment Start Date:		
Medication Managed by:		
ICD-10-CM:		
Treatment Plan:		

SIGNATURE: _____ DATE: _____

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INTAKE QUESTIONNAIRE

Patient Name: _____ DOB: _____

Please list any current medical conditions: _____

_____

_____

Have you previously been treated for a mental health condition? ☐ **YES** ☐ **NO**

If yes, How long ago? _____

How long did you receive treatment? _____

Previous diagnoses? _____

Please list any medication allergies: _____

Current prescribed or OTC medications:	Dose:	Frequency:	Purpose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please include ALL current medications above, if more space is needed, continue onto next page.

**All controlled substances will be cross-referenced via CURES (Controlled Substance Utilization Review and Evaluation System) prior to your appointment and any discrepancy will be addressed with your psychiatrist.*

SIGNATURE: _____ DATE: _____

Telehealth location-CA

1225 Cypress Ave Street 3 Los Angeles, California 90065
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Current medications (continued):	Dose:	Frequency:	Purpose:

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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.

We at ***KEL HEALTH AND WELLNESS CENTER, INC*** understand that medical information about you and your health is personal and we are committed to protecting that medical information. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of used and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we will disclose your information to other physicians within our practice that may be involved in your care.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us. For example, obtaining authorization for office visits may require that your relevant protected health information be disclosed to your health plan/insurance carrier to obtain approval for the services required.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities.

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We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

As Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by Federal, State or local laws. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures. For example, disclosures to a Judge of the Superior Court in response to a court order.

Public Health Agencies: We may disclose your protected health information for public health activities. To report disease, injury, vital events and to conduct public health surveillance, investigation and/or intervention. To a health oversight agency for oversight activities authorized by law including audits, investigations, inspections, licensure and for accreditation or disciplinary actions, administrative and/or legal proceedings. To prevent or lessen a serious threat to the health or safety of another person or the public and as authorized by laws relating to workers compensation or similar programs. To the coroner, medical examiner or a funeral director, to an organ donation and procurement organization if you are an organ donor.

Notification in case of a Breach: We are required by law to notify you in case your unprotected health information has been or is reasonably believed to have been disclosed as a result of a breach.

Any other uses: Including uses and discloses of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will be made only with your written authorization

Uses and Disclosures of Protected Health Information with your written authorization: To provide patient Protected Health Information to other people for reasons other than for treatment, payment or healthcare authorization or as required or permitted by law we must have your written authorization.

You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object: Unless you object, we may disclose to a member of your family, a relative, a close friend

or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location and general condition. We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Inspect and Copy your Protected Health Information. In accordance with State and Federal laws governing protected confidential medical information, you have the right to inspect and copy medical information that may be used to make decisions regarding your treatment. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results when your access is restricted by law. We may also deny a request for access to protected health information if a licensed health care professional has determined, in the exercise of professional judgment, that the access request is reasonably likely to endanger your life or physical safety or that of another person; the protected health information makes reference to another person and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person. Depending on the circumstances, a decision to deny access may be reviewable in accordance with applicable federal law. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. This request must be made in writing. Your physician is not required to agree to a restriction that you may request.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we contact you only by mail or at work. We will accommodate reasonable requests. Please make this request in writing to our Privacy Officer.

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You have the right to request your physician amend your protected health information. If you feel that information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information was created and kept by the practice. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact the Privacy officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure. Your request must state a time period, which may not be longer than six years and may not include dates prior to April 14, 2003.

Out of Pocket Payments: If you have paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment of health care operations and we will honor that request.

3. **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with KEL HEALTH AND WELLNESS CENTER, INC or with the Secretary of the Department of Health and Human Services. To file a complaint with the KEL HEALTH AND WELLNESS CENTER, INC, contact the Privacy Officer. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at KEL HEALTH AND WELLNESS CENTER, INC by calling (000) 000-0000

A copy of this notice is available upon request.