**PERSONAL INFORMATION**

**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_\_\_\_**

**ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**HOME PHONE \_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IS IT ACCEPTABLE FOR DR. KAVIRAJAN TO LEAVE MESSAGES FOR YOU**

**ON THIS PHONE LINE? YES\_\_\_\_ NO\_\_\_\_**

**CELL PHONE \_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IS IT ACCEPTABLE FOR DR. KAVIRAJAN TO LEAVE MESSAGES FOR YOU**

**ON THIS PHONE LINE? YES\_\_\_\_ NO\_\_\_\_**

**NAME OF EMPLOYER (IF APPLICABLE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WORK PHONE \_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(IF REFERRED BY THERAPIST OR PHYSICIAN)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAST PSYCHIATRIC TREATMENT INFORMATION**

1. Have you ever been treated with psychotropic medications (antidepressants, mood stabilizers, antipsychotics, sleep medications, or anti-anxiety medications)? YES NO

2. If your answer to question 1 was “yes,” please list below the names of the medications, the approximate time period of treatment and any positive or negative effects of treatment.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of drug | Approx dates used | Positive effects | Side Effects | Other comment |
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3. If you are current seeing a psychotherapist/counselor, please provide the name and contact information of your therapist.

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Optimal treatment involves coordination of treatment among your healthcare providers. In order for me to share information about your treatment with your therapist, I will need you to complete the form titled “Consent to release information from Dr Kavirajan,” which can be downloaded from my website.

**MEDICAL INFORMATION FORM**

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST ALL MEDICAL CONDITIONS (i.e., high blood pressure, diabetes, thyroid disease, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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LIST ALL SURGERIES (Include date of procedure)

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CURRENT MEDICATIONS/ SUPPLEMENTS/ VITAMINS (Include dose)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRUG ALLERGIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any head injuries with loss of consciousness? Yes \_\_\_ No \_\_\_

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CIGARETTE/CAFFEINE/ALCOHOL/DRUG USE**

Do you currently smoke cigarettes? Yes\_\_\_ No\_\_\_\_

If not currently a smoker, have you smoked in the past? Yes \_\_\_ No\_\_\_\_.

When did you quit smoking (if applicable)?

Number of years of smoking \_\_\_\_\_ Packs per day \_\_\_\_\_

Do you drink caffeinated coffee or tea? Yes \_\_\_ No\_\_\_\_

If so, please indicate how much of each you consume:

Tea \_\_\_\_ # of cups or glasses/day

Coffee \_\_\_ # cups/day

Do you consumealcohol? Yes\_\_\_ No\_\_\_

How many days per week do you consume alcohol ? \_\_\_\_

How many drinks do you typically consume when you drink? \_\_\_\_

(1 drink= 1 beer; 4 oz wine, 1.5 oz of hard liquor)

Was there a time in the past when you drank significantly more than currently? Yes\_\_\_\_ No\_\_\_\_

Have you ever had a DUI or other legal issue related to alcohol use? Yes\_\_\_\_ No\_\_\_\_

Do you feel that alcohol use has had any adverse effects on your life? Yes\_\_\_\_ No\_\_\_\_

Do you use marijuana? Yes\_\_\_\_ No\_\_\_\_

If so, how many days per week do you typically use it? \_\_\_\_

Has your marijuana use caused you any problems? Yes\_\_\_\_ No\_\_\_\_

Please indicate whether you currently use any of the substances below, or if you have used them in the past

|  |  |  |
| --- | --- | --- |
| Drug | Current use (indicate -# of days per week or month) | Past Use indicate -# of days per week or month) |
| Opiates (e.g., Vicodin, dilaudid, methadone, oxycodone, morphine, heroin) |  |  |
| Benzodiazepines (e.g., Xanax, valium, clonazepam, Ativan, etc) |  |  |
| Methamphetamine |  |  |
| Cocaine |  |  |
| Hallucinogens (e.g., mushrooms, LSD, ecstasy) |  |  |
| Bath Salts |  |  |
|  |  |  |

**REVIEW OF SYSTEMS**

PLEASE PLACE A CHECKMARK IF YOU CURENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS.

CONSTITUTIONAL: fever\_\_\_\_\_\_ weight gain/weight loss\_\_\_\_\_\_ fatigue\_\_\_\_\_\_\_

EYE: blurring\_\_\_\_\_ flashing lights\_\_\_\_\_ double vision\_\_\_\_\_ eye pain\_\_\_\_\_

eye redness\_\_\_\_ loss of vision\_\_\_\_\_ eye dryness\_\_\_\_\_

GASTROINTESTINAL: nausea\_\_\_\_ vomiting\_\_\_\_ constipation\_\_\_\_ diarrhea\_\_\_\_\_

blood in stool\_\_\_\_\_ “heartburn”\_\_\_\_\_\_ loss of control of bowel\_\_\_\_\_

EAR/NOSE/THROAT: difficulty hearing\_\_\_\_ ringing in ears\_\_\_\_\_ dizziness\_\_\_\_\_

ear pain\_\_\_\_\_ difficulty swallowing\_\_\_\_ hoarseness\_\_\_\_\_ nosebleeds\_\_\_\_\_\_

CARDIOVASCULAR: chest pain\_\_\_\_ palpitations\_\_\_\_ irregular heart beat\_\_\_\_

RESPIRATORY: shortness of breath\_\_\_\_ cough\_\_\_\_

GENITOURINARY: urinary incontinence\_\_\_\_ difficulty initiating urine flow\_\_\_\_

blood in urine\_\_\_\_ sexual dysfunction\_\_\_\_

MUSCULOSKELETAL: joint pain\_\_\_\_\_ muscle pain\_\_\_\_ joint swelling\_\_\_\_

SKIN: change in color\_\_\_\_ rash\_\_\_\_ change in nails\_\_\_\_

BREAST: discharge\_\_\_\_\_ lumps/masses\_\_\_\_

NEUROLOGIC: headaches\_\_\_\_ seizures\_\_\_\_ fainting\_\_\_\_

weakness/numbness in particular parts of body\_\_\_\_\_

HEMATOLOGIC: abnormal bleeding/bruising\_\_\_\_

ENDOCRINE: excessive thirst\_\_\_\_ excessive urination\_\_\_\_\_ cold/heat intolerance\_\_\_\_

**Policies and Procedures**

Financial Terms

It is expected that patients assume financial responsibility for their treatment. In addition, patients are financially responsible for missed sessions or sessions cancelled with less than 24 *business* hours notice. (For Mondays and days after holidays, appointments must be cancelled by noon on the previous *business* day).

Since Dr. Kavirajan has opted out of Medicare, no claims can be filed with Medicare/CMS for his services.

Phone contact other than brief (5 minutes or less) calls may be subject to charges at the rate of $100 for up to 15 minutes.

Calls to insurance companies for “prior authorization” will be subject to $100-$150 charge, reflecting the typical 15-20 minutes usually required to complete these reviews.

Routine Phone Calls

Non-urgent clinical questions can be left on Dr. Kavirajan’s confidential voicemail at (949) 422-6814. On weekdays, Dr. Kavirajan typically returns calls within the same day; on exceptionally busy days, non-urgent calls may be returned on the next business day. Non-urgent calls on weekends and holidays are returned on the next business day. Please make sure to provide a callback number, even if you think he already has your number. In addition, please state if, because of privacy concerns, you do not want Dr. Kavirajan to leave a message on your voicemail or answering machine in response to your question(s), i.e., if you are concerned that others in the household may retrieve the message.

Emergency Procedures

In the event of a clinical emergency, such as acute thoughts of harming oneself or others or a medically dangerous reaction to a medication, Dr. Kavirajan can be reached through the urgent contact line specified on his voicemail. If you are facing a true clinical emergency such as imminent danger to self or others, you should call 911 or go to your local emergency room as you are waiting for a return call from Dr. Kavirajan. In addition, you might consider calling your insurance company’s customer service number to locate the nearest emergency treatment facility that is covered by your insurance carrier.

Please note that Dr. Kavirajan’s emergency contact line is to be used for true emergencies only. Unusually frequent or prolonged use of this service may incur charges at a rate of $100 per 15-minute period or portion thereof. In addition, in cases where emergency access is used with excessive frequency, continued treatment with Dr. Kavirajan may become contingent on an increase in frequency of sessions, treatment at a higher level of care (partial hospital or inpatient treatment), involvement of family members in monitoring safety and compliance (if appropriate) or other modifications of treatment designed to enhance the patient’s stability.

Limits of Confidentiality

Information collected by physicians and therapists in evaluation and treatment of patients is considered confidential. However, there are certain instances where such healthcare providers are required or allowed by law to make exceptions to this confidentiality. Examples of these situations include the following:

1. The patient authorizes a release of information to a designated recipient. (Dr. Kavirajan’s patients may provide such authorization by completing the form titled “Consent for Release of Information from Dr. Kavirajan,” available from the “Forms” menu on his website.)

2. Dr. Kavirajan is provided with information leading him to believe that a patient is at risk for harming self or others, or is unable to meet his/her basic needs.

3. Information presented to Dr. Kavirajan indicates that child or elder abuse/neglect is occurring.

4. A court has ordered release of records.

5. Other reporting requirements mandate release of patient information (i.e., a patient with dementia whose ability to operate a motor vehicle is potentially compromised).

6. A third party payer, i.e, an insurance company, is involved in payment for any aspect of evaluation or treatment, such as office visits, laboratory tests, or medications. Insurance companies usually require information on dates or service, diagnoses, and types of office visit (initial evaluation or follow-up), but other information may be required before payment is authorized.

By signing below, I acknowledge that I have read the above policies/procedures and am undertaking treatment with Dr. Kavirajan with full awareness and acceptance of the policies and procedures governing his practice and that I have reviewed the advisement below regarding physician licensing and regulation:

NOTICE TO CONSUMERS:

Medical Doctors are licensed and regulated by the

Medical Board of California.

800 633-2322

www.mbc.ca.gov

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME OF PATIENT/RESPONSIBLE PARTY