PERSONAL INFORMATION

NAME _____ DATE OF BIRTH ___/___/_____

ADDRESS _____

_____

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

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.)

_____
_____
_____
_____
_____
_____
_____
_____

LIST ALL SURGERIES (Include date of procedure)

_____
_____
_____
_____
_____

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 consume alcohol? 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