

DAVID M. LECHUGA, PH.D.  
DIRECTOR  
CA LICENSE PSY10139

13 ORCHARD ROAD, SUITE 103  
LAKE FOREST, CALIFORNIA 92630  
949.837.3358 FAX 949.837.0274

## NEW PATIENT INFORMATION/REGISTRATION

(PLEASE PRINT)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Party Responsible for Account (if there is insurance this should be the insured person's information)

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Occupation \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Person to Notify in an Emergency \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Referred by \_\_\_\_\_

### Primary Insurance Information

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Insurance \_\_\_\_\_

Insurance Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Ins. Phone Number (\_\_\_\_) \_\_\_\_\_ Insured's SSN \_\_\_\_\_

Insured's Relationship to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Insured's Policy/Certificate Number \_\_\_\_\_ Group Number \_\_\_\_\_

## Secondary Insurance Information

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Secondary Insurance \_\_\_\_\_  
Insurance Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Ins. Phone Number (\_\_\_\_) \_\_\_\_\_ Insured's SSN \_\_\_\_\_  
Insured's Relationship to Patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_  
Insured's Policy/Certificate Number \_\_\_\_\_ Group Number \_\_\_\_\_

### **Financial Agreement:**

I fully understand and agree to the following:

1. I am fully responsible for all fees in connection with professional services rendered to me or my minor child/dependent by David M. Lechuga, Ph.D. and/or The Neurobehavioral Clinic Staff.
2. I am fully responsible for all missed appointments or cancellations with less than 24 hours advance notice. A fee equal to the charge for the session scheduled will be charged for each such missed/canceled appointment.
3. My account is due and fully payable within 30 days of date of service unless other arrangements are made in writing.
4. Delinquent accounts (those not fully paid within 90 days of date of service or presentation of the first statement/bill) will be subject to a finance charge of 1.5 percent per month or 18.0 percent per year, unless other arrangements are made in writing.
5. If my account is referred for collection through legal channels, I will be responsible for all reasonable court costs and attorney/collection agency fees in connection with such action.
6. If health insurance is involved, the office of David M. Lechuga, Ph.D. will bill my insurance carrier only as a courtesy to me. I am still fully responsible for all fees and charges which my insurance carrier does not cover or pay for.
7. I authorize David M. Lechuga, Ph.D. and/or The Neurobehavioral Clinic Staff to disclose information about my illness/condition to my insurance carrier for the purpose of processing my claim. This information may include data about my history, diagnosis, and examination findings. I also authorize direct payment of insurance benefits to David M. Lechuga, Ph.D. and/or The Neurobehavioral Clinic by my insurance carrier.
8. I understand that I have been referred to David M. Lechuga, Ph.D. for neuropsychological/ psychological evaluation and/or psychotherapy by my physician, psychologist, attorney, therapist, or counselor. The purpose of these procedures has been explained to me and I agree to participate in them.

I have been advised of the costs involved with these procedures and agree to them. The costs are \$200.00 per hour for all services. If we incur finance charges for returned checks, these charges will be added to your bill. A \$500.00 retainer fee is required for all testing or evaluation cases, unless otherwise specified by Dr. Lechuga or his staff.

I have read all of the above terms carefully, understand them, and agree to them.

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Name of Patient (Please Print)

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Signature of Patient (or parent if minor)

Date

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Witness

Date

## **Office Policies and General Patient Information Professional Services Agreement**

Welcome to The Neurobehavioral Clinic. Important information about our professional services and business policies are described below. Please read this information carefully, so that we may discuss any questions or concerns you have during our first appointment.

### **Privacy Practices:**

We are obligated by law to safeguard your health information. We may only disclose your health information under the following conditions:

1. For Treatment:

We may need to communicate with other health care professionals about you<sup>1</sup>. This communication would be in the service of improving our understanding of you and your health. Prior to disclosing information about you, we will obtain your specific and written consent to do so.

2. For Payment:

We may need to disclose your health information for billing and collection activities. Sometimes, insurance companies wish to review detailed information about our services. We will disclose only the information needed to procure payment for services rendered.

3. For Office Purposes:

We need to share your health information with our clinic's office staff. Our administrative staff is instrumental to billing, record review, and quality care management.

There are some conditions under which your health information may be disclosed without your authorization. These would be:

1. When we are required to do so by law. This would occur whenever abuse, neglect, or domestic violence is suspected.

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<sup>1</sup> "You" pertains to an individual adult patient or a minor patient. A parent or other legal representative must review this document on behalf of the minor.

2. For public health activities, as required by Federal or State law.
3. During judicial and administrative proceedings, as requested via a court order, subpoena discovery request, or other lawful process.
4. For law enforcement activities, such as identifying or locating a suspect, fugitive, material witness or missing person, or reporting crimes in emergencies, or reporting a fatality.
5. When relating to survivors of patients who have died.
6. To avert a serious threat to your health and safety, or the health and safety of another.

**Your Rights Regarding Your Health Information:**

You have the right to view and obtain copies of your health information within our clinic. You must make this request in writing. Under certain circumstances, we may deny your request. If this occurs, we will provide you with the reasons for this denial. You will not be charged more than \$ .25 per page for a copy of your health information.

You have the right to request limits on the uses and disclosures of your health information. If we do not agree on these limitations, a rationale will be provided to you in writing.

You can choose how your health information is sent to you. Some individuals prefer regular mail. Others prefer email or alternative delivery options.

You have a right to know to whom I have made disclosures about your health information.

You have a right to amend your health information.

You have a right to complain about our Privacy Practices. You may contact the Secretary of the U. S. Department of Health and Human Services @ 200 Independence Ave., S.W., Washington, D. C., 20201.

**What is Important to Know About Our Clinical Services:**

We see children, adolescents, and adults. We do evaluations and provide psychotherapy services. We will discuss our recommended course of care with you within the first sessions. Usually, evaluations are performed across two or three dates. Psychotherapy may occur weekly in 45-minute sessions.

If you must reschedule your appointment, please try to do so 24 hours prior to the appointment. With the exception of unforeseen events or emergencies, appointments, which are missed or cancelled within 24 hours will be charged to you (one 45-minute session for therapy appointment; two hours for testing appointment). Insurance does not pay for missed appointments.

Professional fees will be discussed with you prior to your first appointment. You or your insurance company will be charged according to an hourly rate if there is a need to speak to other professionals on your behalf, review records, or prepare reports.

You will be billed at the end of a month. Unless other agreements are made in advance, you will be responsible of the prompt payment of whatever your insurance company does not cover.

**Contacting Us:**

Call our office phone number. Each of us has a different extension. We try to return routine phone calls within one business day. We each have various ways in which you can reach us during an emergency. These will be discussed with you during the first appointment.

*I have read the above office policies and General Patient Information. I understand them and agree to comply with them.*

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**Patient (Legal Representative if patient is minor)**

**Signature**

**Date**


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**Healthcare Professional**

**Signature**

**Date**

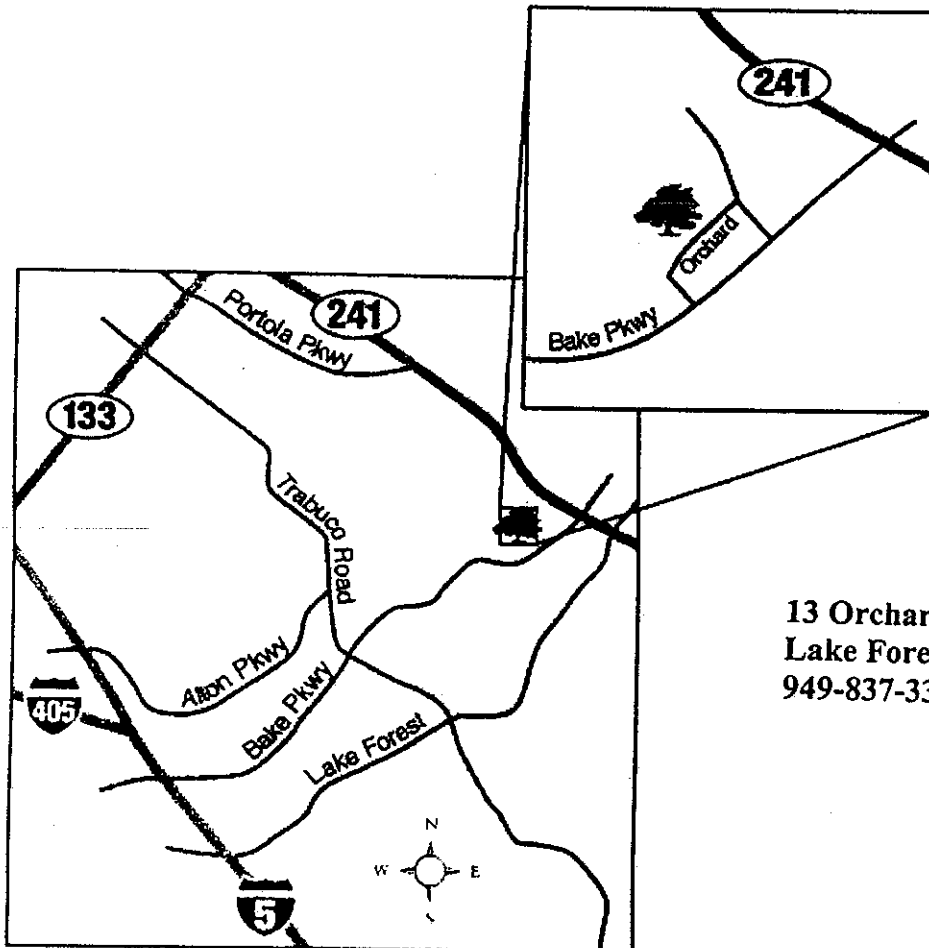




**THE  
NEUROBEHAVIORAL  
CLINIC**  
*and Counseling Center*

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**From the 5 or 405 freeway**

- Exit Bake and go northeast
- Travel toward mountains (approximately 5 miles)
- Turn left on Rancho Parkway South
- Turn left on Orchard Road
- Turn right into 3<sup>rd</sup> driveway on right
- We are in 3<sup>rd</sup> building on right

**From the 241 Toll Road**

- Exit Alton Parkway
- Travel east toward the mountains
- Turn Right on Towne Center Drive
- Turn Right on Bake
- Turn Right on Rancho Parkway South
- Turn Left on Orchard Road
- Turn right into 3<sup>rd</sup> driveway
- We are in 3<sup>rd</sup> building on right