THE NEUROBEHAVIORAL CLINIC & Counseling Center

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_____

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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 _____

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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. arid/or The Neurobehavioral Clinic Staff.
2. I am fully responsible for all missed appointments and/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 $250.00 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.

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

_____

Name of Patient *(Please Print)*

_____ _____

Signature of Patient **Date**
(Or Parent if patient is a minor)

_____ _____

Witness **Date**

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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[1]. 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.

2. For public health activities, as required by Federal or State law.

[1]"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.

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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

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Patient Agreement and Office Policies

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 for 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.

_____ _____

Patient Signature **Date**

(Legal Representative if patient is a minor)

_____ _____

Healthcare Professional Signature **Date**

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Your Questions or Concerns

Please use the space below to write down any questions or concerns you have about our office policies or clinical services. These issues can be addressed during our first appointment.

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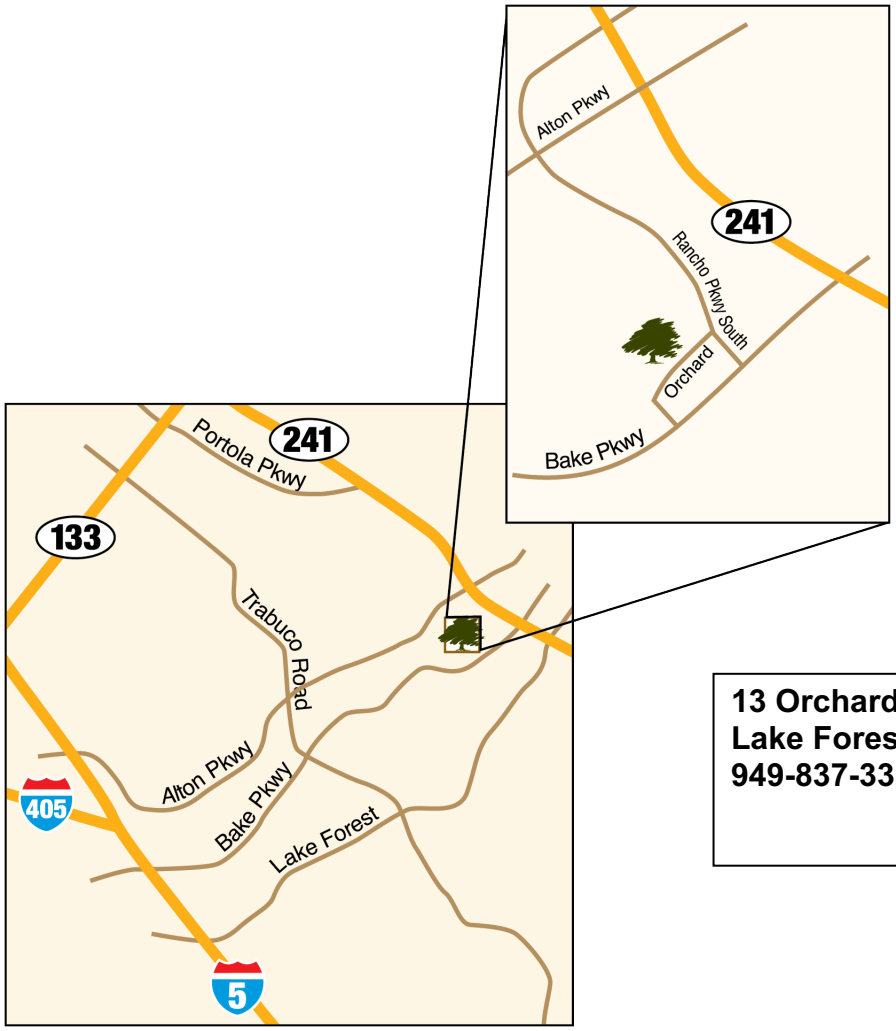

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From the 5 or 405 freeway	**From the 241 Toll Road**
• Exit Bake and go northeast • Travel toward mountains (approximately 5 miles), • Tum left on Rancho Parkway South • Tum left on Orchard Road • Tum right into 3rd driveway on right • We are in 3rd building on right	• Exit Alton Parkway • Travel east toward the mountains • Turn Right on Towne Center Drive • Turn Right on Bake • Turn Right on Rancho Parkway South • Tum Left on Orchard Road • Tum right into 3rd driveway • We are in 3rd building on right