Hope W. Levin, M.D.
310-494-0108

Contact Information

Patient name: _____

Date of birth: _____

Address: _____
_____

Cell: _____ O ok to leave message?
Home: _____ O ok to leave message?
Work: _____ O ok to leave message?

Parent name: _____

Address: _____
_____

Cell: _____ O ok to leave message?
Home: _____ O ok to leave message?
Work: _____ O ok to leave message?

Parent name: _____

Address: _____
_____

Cell: _____ O ok to leave message?
Home: _____ O ok to leave message?
Work: _____ O ok to leave message?

Emergency contact:

Name: _____
Relationship: _____
Phone: _____

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Medical History

Current medications: (include herbal, supplements, etc.)

Past psychiatric medications:

Allergies to medications:

Primary care doctor/pediatrician name and phone:

Medical problems: (current or significant past history)

Seizures? ____ Y ____ N

Heart problems? ____ Y ____ N

Thyroid problems? ____ Y ____ N

Serious accidents? ____ Y ____ N

Surgeries? ____ Y ____ N

Head trauma? ____ Y ____ N

(please explain any "yes" responses)

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Medical History - continued

Alcohol use:

Drug use:

Cigarette use:

Family history of psychiatric problems:
(including depression, anxiety, ADHD, eating disorder, bipolar, schizophrenia, suicide, drug/alcohol problems)

Family history of general medical problems:

Office Policies

Financial:

1. Payment by credit card, cash or check is required in full at the time of your appointment.

2. Any appointment missed or cancelled without 48 hours advanced notice will be charged the full professional fee, except in the case of an emergency.

3. There is a $25 returned check fee.

4. Dr. Levin is a private practitioner and is not a participating member of any insurance panels. Financial statements ("super bills") are available for submission to your health insurance company for you to seek reimbursement for professional services. Please consult with your insurance company to determine what percentage of fees they will reimburse.

5. Failure to pay for multiple sessions, multiple late cancellations or repeated missed appointments might, at discretion of the doctor, result in discharge from the practice. In such circumstances, referrals to another psychiatrist or clinic will be provided.

Communication:

1. Voicemail messages left during business hours will be returned promptly.

2. Messages left on evenings, weekends and holidays will be returned the following business day.

3. For urgent issues, you may have me paged at 424-442-0194 . Pages will generally be returned within one to two hours.

4. In the event of a life-threatening emergency, please go to your closest emergency room or call 911.

Confidentiality:

1. The content of sessions is confidential except in the following situations: in cases where a patient may be a danger to self or others, in cases of suspected child or elder abuse, in cases where a patient may be incapable of taking care of him/herself, certain legal proceedings when required by a judicial subpoena.

2. My professional records are separately maintained and no one else can have access to them without your specific, written permission.

California Prescription Drug Monitoring Program (PDMP):

1. Dr. Levin routinely uses the State of California Department of Justice Prescription Drug Monitoring Program to access controlled substance prescription history.

2. More information about the PDMP can be found online at https://pmp.doj.ca.gov/pdmp

Acknowledgement of Independent Practitioner:

1. Dr. Levin is an independent practitioner. Although other mental health professionals work in the office suite, Dr. Levin is not in partnership with them and has no responsibility for their billing. She neither controls nor supervises the services they provide.

Evaluation and Treatment Consent

Your signature below indicates that you have read the above office policies and you agree to abide by the terms during our professional relationship.

The undersigned patient or responsible party (parent, legal guardian) consents to, and authorizes services, by Hope W. Levin, M.D. These services may include evaluation, psychotherapy, medication therapy and laboratory tests.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

Signature of patient or legal guardian: _____

Patient name: _____

Date:_____

Relationship to patient, if applicable:_____

Acknowledgement of Receipt for 'Notice of Privacy Practices' (HIPAA)

I have received (paper or online version) the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of patient or legal guardian: _____

Patient name: _____

Date:_____

Relationship to patient, if applicable:_____