Dennis Patrick Wood, Ph.D., ABPP

1050 B Avenue, Ste B
Coronado, CA 92118
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CA State License #PSY19293

PATIENT INFORMATION

TODAY'S DATE	ARE YOU A NEW PATIENT? ☐ Yes ☐ No	**FOR PROVIDER USE ONLY** **DX:**

FIRST NAME	MIDDLE NAME	LAST NAME

MAILING ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE
( ) -	( ) -	( ) -

E-MAIL ADDRESS *(OPTIONAL)*	BIRTHDATE	AGE	SEX	ETHNICITY *(OPTIONAL)*
			☐ M ☐ F	

SOCIAL SECURITY #	DRIVER'S LICENSE #	MARITAL STATUS
		☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

EMPLOYMENT STATUS	STUDENT STATUS
☐ Full-Time ☐ Part-Time ☐ Retired ☐ None ☐ Self Employed ☐ Active Military	☐ Full-Time ☐ Part-Time ☐ None

RESPONSIBLE PARTY INFORMATION

(Only IF Different from Patient Information Above)

FIRST NAME	MIDDLE NAME	LAST NAME

BILLING ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE
( ) -	( ) -	( ) -

RELATIONSHIP OF PATIENT TO RESPONSIBLE PARTY	SOCIAL SECURITY #	DRIVER'S LICENSE #
☐ Spouse ☐ Child ☐ Other (Specify)_____		

INSURANCE INFORMATION

(Please Provide Copies of ALL I.D. Cards – FRONT and BACK, If Applicable)

☐ Please Check Here If You Have No Insurance And You Will Be Solely Responsible For Payment (*Skip to the next page*).

PRIMARY INSURANCE NAME	SECONDARY INSURANCE NAME

INSURANCE PHONE NUMBER	EFFECTIVE DATE	INSURANCE PHONE NUMBER	EFFECTIVE DATE
( ) -		( ) -	

CLAIMS ADDRESS	CLAIMS ADDRESS

CITY STATE ZIP	CITY STATE ZIP

SUBSCRIBER'S NAME	SEX	DATE OF BIRTH	SUBSCRIBER'S NAME	SEX	DATE OF BIRTH
	☐ M ☐ F			☐ M ☐ F	

SUBSCRIBER'S I.D. #	GROUP #	SUBSCRIBER'S I.D. #	GROUP #

SUBSCRIBER'S EMPLOYER	DEDUCTIBLE $	COPAYMENT $	SUBSCRIBER'S EMPLOYER	DEDUCTIBLE $	COPAYMENT $

RELATIONSHIP OF PATIENT TO SUBSCRIBER	RELATIONSHIP OF PATIENT TO SUBSCRIBER
☐ Self ☐ Spouse ☐ Child ☐ Other _____	☐ Self ☐ Spouse ☐ Child ☐ Other _____

FOR WORKERS COMPENSATION INSURANCE ONLY, PLEASE SPECIFY

Date of Injury _____ State in Which Injury Occurred _____

CONSENT TO DISCLOSE ACCOUNT INFORMATION

According to State and Federal confidentiality laws, we cannot disclose any information about you to any other person without your consent. This includes other family members, unless you are less than 18 years old or under certain legal circumstances.

I understand that "information" includes activities involved in determining my eligibility for health plan coverage, billing and receiving payment from myself and from my health insurance plan, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

I authorize this medical provider to disclose details of my account and my care to the following person(s) to ensure that payment is received for the services rendered to me.

☐ ***PLEASE CHECK HERE IF YOU DO NOT WISH ANYONE ELSE TO HAVE ACCESS TO YOUR FINANCIAL INFORMATION.***

FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN NAME			PHYSICIAN PHONE
			( ) -
PRIMARY CARE PHYSICIAN ADDRESS (IF KNOWN)	CITY	STATE	ZIP

MAY WE CONTACT YOUR PHYSICIAN SO THAT THIS PROVIDER MAY BE FULLY INFORMED AND WE MAY COORDINATE YOUR TREATMENT?

☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT
HOME PHONE	WORK PHONE	CELL PHONE
( ) -	( ) -	( ) -

HOW DID YOU HEAR ABOUT US?

☐ Doctor Referral	☐ Insurance Company	☐ Magazine or News Article	☐ Yellow Pages
☐ Friend or Relative	☐ Internet or Web Site	☐ Television	☐ Other _____

NAME / DETAILS	PHONE NUMBER	MAY WE CONTACT THIS PERSON?
	( ) -	☐ Yes ☐ No

POLICY STATEMENT

Thank you for choosing our office for your ***psychiatric*** needs. We are committed to your treatment being successful. Please understand that payment of your services is considered part of your treatment. The following sets forth the terms and conditions upon which our services are rendered.

CONSENT OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: I hereby consent to the use or disclosure of my protected health information by ***Dennis Patrick Wood, Ph.D., ABPP*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis and treatment of me is conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of this medical practice. ***Dennis Patrick Wood, Ph.D., ABPP*** is not required to agree to the restrictions that I may request. However, if this office agrees to any restriction that I request, then this restriction is then binding. I have the right to revoke this consent, in writing, at any time, except to the extent that ***Dennis Patrick Wood, Ph.D., ABPP*** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by this provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical health, mental health or condition, and identifies me, or if there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ***Dennis Patrick Wood, Ph.D., ABPP's*** Notice of Privacy Practices prior to signing this document. This Notice of Privacy Practices is posted in the waiting room, or a copy is available upon my written request.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This Notice of Privacy Practices also describes my rights and the duties with respect to my protected health information.

I understand that this medical office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting it in writing, either by mail or at my next appointment, and a revised copy be sent in the mail or will be provided to me at the time of my next appointment.

CONFIDENTIALITY: Professional ethics and California state law specifies that communications to medical staff are confidential and privileged, and cannot be released or shared without the express written permission of the patient, except as noted above. However, there exist a few instances that are mandated by law to report certain information. These include, but are not limited to, abuse of minor, or if you express the intent of bringing harm to yourself or another person. In such circumstances, the provider is required to inform potential victim(s) and legal authorities.

PAYMENT OF FEES: Payment for services is the patient's responsibility (or parent/guardian, if patient is a minor.) I agree to pay my share of the charges, such as co-payment and deductible amounts, at the time of each visit. The charge for each appointment depends upon the time I spend with the physician, and the type of visit for which I am seen. I understand that ***Dennis Patrick Wood, Ph.D., ABPP****'s* fees are within the usual and customary rates for medical services in the San Diego area. For specific dollar amounts, please ask the office staff. Please note that this office charges a $25 service fee for all returned checks.

INSURANCE: This office will submit your insurance claims to your carrier, at no cost to you. However, we are not in a position to guarantee payment from your insurance company since the claim is based upon arrangements between you and the insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. I understand it is my responsibility to know if this is true.

PRIOR AUTHORIZATION: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s).

APPOINTMENTS: Your appointment time has been reserved exclusively for you. I agree that if I fail to cancel my appointment with at least 24 hours advance notice I may be billed for the full fee at the discretion of ***Dennis Patrick Wood, Ph.D., ABPP*** I understand that insurance companies do not cover missed appointments.

MEDICAL RECORDS: I understand that ***Dennis Patrick Wood, Ph.D., ABPP*** will retain my medical records for seven years as per legal requirements. Copies of records can be transferred to other health care providers upon receipt of a valid written consent. I understand that this office requires at least 72 hours notice prior to medical records being made available to the authorized party.

MEDICATIONS: I understand that medication refills will be considered during office hours only. This is so this office can conform with California Pharmacy statutes, and to prevent the possibility of other persons from acting or posing as patients of ***Dennis Patrick Wood, Ph.D., ABPP***, or obtaining medication illegally. I further understand that if I should need to have a prescription refilled that I should contact my pharmacy at least 1-2 days prior to needing the medication or the medication may not be available to me the same day. I understand refills for any medication will not be performed unless I have been seen within the last six months.

AGREEMENTS: I have reviewed the preceding information and I certify that this information is accurate. I further understand that I am responsible for any financial loss due to incomplete or inaccurate information provided by me.

I hereby authorize payment directly to this medical provider any insurance benefits that would otherwise be payable to me for services rendered.

In instances where insurance does not pay any benefits, I agree to pay for those services. If payment is not received within 90-days from the date the claim was submitted, I agree that I will become responsible for the full amount of the balance on my account.

Should I break the financial arrangements as detailed above, I agree that my name may be released for collection purposes. I understand that no treatment related information will accompany this disclosure. I also agree that if any legal action is taken to enforce the provisions of this Policy Statement that the prevailing party shall be entitled to reasonable attorney's fees and costs.

I have read this Policy Statement and agree to the terms as stated:

_____ _____Initial here, if you would like
PATIENT'S NAME (Please Print) a copy of this policy statement.

_____ _____
RESPONSIBLE PARTY (Signature) DATE