# Loma Linda Psychiatric Medical Group

## Patient Information Sheet

| Last Name: Little | First Name: Madden | MI: |
|---|---|---|

| Date of Birth: 11/18/2014 | Sex: (•) Male ( ) Female | Home Phone: | Cell Phone: 9097352027 |
|---|---|---|---|

| Marital Status: (•) Minor ( ) Married ( ) Single ( ) Divorce ( ) Widowed | Social Security #: | Driver's License #: |
|---|---|---|

Home Address: 1370 orange st unit c Redlands ca 92374

| Language: | Religion: | Race/Ethnicity: ☐ African American/Black ☐ White ☐ Asian ☐ Hispanic ☐ American Indian or Alaska Native ☐ Pacific Islander ☐ Other |
|---|---|---|

**EMERGENCY CONTACT INFORMATION**

| Last Name: Sogbesan | First Name: Stacey |
|---|---|

| Relationship to Patient: Mother | Contact #: 9097352027 |
|---|---|

**PRIMARY INSURANCE INFORMATION**

Primary Insurance Name: IEHP

| Primary Subscriber: ☐ Self ☐ Spouse ☐ Parent ☐ Other: | | Date of Birth: |
|---|---|---|
| Subscriber's ID Number: | Group #: | C.D.L. #: |

Employer's Name:

**SECONDARY INSURANCE INFORMATION**

Primary Insurance Name:

| Primary Subscriber: ( ) Self ( ) Spouse ( ) Parent ( ) Other: | | Date of Birth: |
|---|---|---|
| Subscriber's ID Number: | Group #: | C.D.L. #: |

Employer's Name:

**DISCLAIMER**: Loma Linda Psychiatric Medical Group is not affiliated with Loma Linda University Health.

# Loma Linda Psychiatric Medical Group

## INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

**Benefits and Risks of Telepsychology**

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

**Electronic Communications**
We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, please contact our office at (909) 370-4700. We will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach us and feel that you cannot wait for us to return your call, please call 911 or go to your nearest emergency room.

**Confidentiality**
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outline in my Informed Consent still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

**Appropriate of Telepsychology**
From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Please contact our office at (909) 370-4700 after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, please contact our office at (909) 370-4700.

**Fees**

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

**Records**

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

**Informed Consent**

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

| | |
|---|---|
| Madden little | 07/14/25 |
| Client | Date |
| | |
| Therapist | Date |

# Loma Linda Psychiatric Medical Group

## Consumer Notice of Rights and Responsibilities

*Dignity and Respect*

- You have the right to be treated with consideration, dignity and respect — and the responsibility to respect the rights, property and environment of all physicians, other health care professionals, employees and other patients.
- You have the right to access your own treatment records and have the privacy and confidentiality of those records maintained.
- You are also entitled to exercise these rights regardless of gender, age, sexual orientation, marital status, culture, economic, educational or religious background.

*Knowledge and Information*

- You have the right to receive information about the organization's services and practitioners, clinical guidelines and member's rights and responsibilities.
- You have the right — and the responsibility — to know about and understand your health care and your coverage, including:
  - Participating with your physician and other healthcare professionals in decision making regarding your treatment planning. Having participated and agreed to a treatment plan, you have a responsibility to follow the treatment plan or advise your provider otherwise.
  - The names and titles of all health care professionals involved in your treatment.
  - Your clinical condition and health status.
  - Any services and procedures involved in your recommended course of treatment.
  - Any continuing health care requirements following your discharge from a provider's office, hospital, or treatment program.
  - How your health plan operates — as stated in your Policy and/or Certificate.
  - The medications prescribed for you — what they are for, how to take them properly and possible side effects.

*Continuous Improvement*

- As a partner with your health plan and any health care professional who may be involved in your care, you have the right to:
  - Contact a Member Service Associate to address all questions and concerns as well as to make suggestions for improvement to the health plan and/or the members' rights and responsibilities policies.
  - Ask questions about any clinical advice or prescribed treatment if you need an explanation or want more information.
  - Appeal any unfavorable behavioral health care decisions by following the established appeal or grievance procedures of your health plan.

*Eligible Employee Accountability/Autonomy*

- As a partner in your own health care, you have the right to refuse treatment — providing you accept responsibility and the consequences of such a decision — and the right to refuse to participate in any medical research projects.
- You have a responsibility to participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals.
- You also have the responsibility to:
  - Provide your current provider with previous treatment records, if requested, as well as provide accurate and complete medical information to any other health care professionals involved in the course of your treatment.
  - Be on time for all appointments and to notify your provider's office as far in advance as possible if your need to cancel or reschedule an appointment.
  - Receive all non-emergent or urgent care through your assigned behavioral health provider and obtain preauthorization of service from Managed Care Company, if applicable.
  - Notify your behavioral health plan within 48 hours — or as soon as possible — if you are hospitalized or receive emergency care.
  - Pay all required co-payments and deductibles at the time you receive behavioral health care services.
- You have the right at any and all times to contact a member service associate for assistance with issues regarding your behavioral health plan.
- It is your right to have all the above rights apply to the person you have designated with legal authority to make decisions regarding your health care. If you have any questions or complaints regarding your rights, contact the member service associated with your insurance company.

Patient or Guardian's Signature: Stacey Sogbesan Date: 07/14/25

# Loma Linda Psychiatric Medical Group

## Mental Health Disclosure Form

*Treatment Philosophy - Explanation of Brief Therapy*

- Brief therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask.

*Limits of Confidentiality Statement*

- All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:
  1. The patient authorizes a release of information with a signature.
  2. The patient's mental condition becomes an issue in a lawsuit.
  3. The patient presents as a physical danger to self (Johnson v County of Los Angeles, 1983).
  4. The patient presents as a danger to others (Tarasoff Regents of University of California, 1967).
  5. Child or Elder abuse and/or neglect are suspected (Welfare & Institution and/or Penal Code).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

- All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion is not to be discussed outside of the counseling sessions.

*Release of Information*

- I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

*Emergency Access*

- Practitioners are only available during office hours. In case of emergencies, call 911 or visit nearest psychiatric ER or call crisis hotline 1-800-273-8255.

*Consent for Treatment*

- I authorize and request my practitioner to carry out psychological exams, treatment and/or diagnostic procedures which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

Patient's Signature: Stacey Sogbesan Date: 07/14/25

***General Consent for Child or Dependent Treatment***

- I am the legal guardian or representative of the patient and, on the patient's behalf, legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient.

Patient Name: Madden little Relationship to Patient: Mother

Guardian's Signature: _____ Date: 07/14/25

# Loma Linda Psychiatric Medical Group

Patient Acknowledgement of Notice of Privacy Practices

I, Madden little,

(Please print your name)

have received the Notice of Privacy Practices and understand that Loma Linda Psychiatric Medical Group has certain legal duties to safeguard my Protected Health Information (PHI). I also understand that I have certain rights in regard to my (PHI).

Patient or Guardian's Signature: Stacey Sogbesan Date: 07/14/25

# Loma Linda Psychiatric Medical Group

## Office Policies

Please read carefully.

*Billing and Payments*

- We accept Medicare and assignment of benefits as well as various private insurances, and will bill your insurance company for you. However, you are responsible for any deductibles, coinsurance amounts and charges not paid by your insurance. We do our best to verify your health plan or insurance coverage and limitations, but you are responsible for keeping us up to date on any changes to your insurance plan or policy.
- Deductibles, co-insurance amounts and copayments for office visits are due at the time of your visit. The amount of your deductible, copayment or co-insurance is determined by your health plan or insurance coverage.
- Payment for non-covered services is due at the time you receive the service.
- Patients with no insurance or who are unable to provide insurance information are required to pay for services at the time they are received.
- LLPMG accepts cash, checks, certain credit cards and debit cards.
- There will be a charge of **$25.00** for each returned check. LLPMG reserves the right to request payment by cash, credit card or debit card from any patient with 2 or more returned checks in any 12-month period.
- Refunds will be issued by check to the address we have on file for you, or your health plan or insurance company. Please allow up to four weeks for refunds to process.

*Forms Completion*

- LLPMG charges for completing certain forms including State Disability forms, DMV Handicapped forms and Doctor's Certificates for a fee of **$10.00**.
- We do not complete forms for health examinations, school/sport physicals or similar examinations.

***For Patients with Insurance Other than IEHP or Medicare***

*Missed Appointments*

- If you must cancel a scheduled appointment, please contact us at least 2 working days in advance.
- If you do not contact us at least one working day in advance and miss your **first appointment** with us, you will be charged a Missed Appointment fee of **$180.00**. This fee must be paid before we can reschedule an appointment with you.
- If you do not cancel a **follow-up appointment** with us at least one working day in advance, you will be charged a Late Cancellation fee of **$40.00**. If you miss a **follow-up appointment** with us, you will be charged a Missed Appointment fee of **$90.00**.
- If you have more than one missed appointment with no cancellation notice, we will require your credit card information and will automatically charge your credit card for future missed appointments.

*Late Arrivals*

- If you arrive more than 15 minutes late for your appointment, you may be rescheduled for a different time and date and will be charged a Missed Appointment fee. Please refer to paragraph above.

Patient or Guardian's Signature: Stacey Sogbesan _____ Date: 07/14/25 _____

Loma Linda Psychiatric Medical Group

*Adult Form*

# Assessment Information

Patient Name: Madden little _____
Last Name First Name Full Middle Name Nickname

Patient Address: 1370 orange st unit c Redlands ca 92374 _____
Street City State Zip

Highest Level of Education: ☐ High School ☐ College - Major: _____

Graduated? ☐ Yes ☐ No

Current Occupation: _____ _____
Student / Job Title School / Employer

_____
School / Work Address

_____
School / Work Phone #

Persons who are living in your home (including self):

| | Name | Age | Sex | Relationship |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

Significant others outside of home:

| | Name | Age | Sex | Relationship | Town/State of Residence |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

# Loma Linda Psychiatric Medical Group

## SYMPTOMS IDENTIFICATION and HEALTH HISTORY

PATIENT'S NAME Madden little

Please state your presenting problem(s) and the length of time you have experienced it/them:

Please take a few minutes to complete the following. Check the number that applies to you.
The numbers range from 0 meaning not present through 4 meaning severe problem

| SYMPTOM | ◄NONE - SEVERE► | | | | |
|---|---|---|---|---|---|
| Crying spells | 0 | 1 | 2 | 3 ● | 4 |
| Extreme tiredness | 0 ● | 1 | 2 | 3 | 4 |
| Feelings of dread | 0 ● | 1 | 2 | 3 | 4 |
| Feelings of hopeless / helpless | 0 ● | 1 | 2 | 3 | 4 |
| Headaches | 0 ● | 1 | 2 | 3 | 4 |
| Hearing voices | 0 ● | 1 | 2 | 3 | 4 |
| Impulse control problems | 0 ● | 1 | 2 | 3 | 4 |
| Loss of appetite | 0 ● | 1 | 2 | 3 | 4 |
| Loss of interest in activities | 0 ● | 1 | 2 | 3 | 4 |
| Loss of interest in sex | 0 ● | 1 | 2 | 3 | 4 |
| Nervousness | 0 | 1 | 2 ● | 3 | 4 |
| | | | | | |

| SYMPTOM | ◄NONE - SEVERE► | | | | |
|---|---|---|---|---|---|
| Nightmares | 0 ● | 1 | 2 | 3 | 4 |
| Panic attacks | 0 ● | 1 | 2 | 3 | 4 |
| Poor concentration | 0 | 1 | 2 ● | 3 | 4 |
| Poor memory | 0 ● | 1 | 2 | 3 | 4 |
| Sadness | 0 ● | 1 | 2 | 3 | 4 |
| Sleep Problems | 0 | 1 | 2 ● | 3 | 4 |
| Suicidal thoughts & plans | 0 ● | 1 | 2 | 3 | 4 |
| Suspiciousness | 0 ● | 1 | 2 | 3 | 4 |
| Weight loss | 0 ● | 1 | 2 | 3 | 4 |
| Worry all the time | 0 ● | 1 | 2 | 3 | 4 |
| Others | 0 ● | 1 | 2 | 3 | 4 |
| | | | | | |

Allergies? ☐ Yes ■ No
If yes, please list _____

Health History ☐ BP ☐ DIABETES ☐ ASTHMA ☐ CORONARY ☐ SURGICAL
☐ Other _____

Past Psychiatric History ☐ Yes ■ No

Psychiatric Hospitalizations ☐ Yes ■ No How many times _____ Last Hospitalized: _____

Familial Psychiatric History ☐ Yes ■ No
If yes, who _____ what _____

# Loma Linda Psychiatric Medical Group

Patient's name: Madden little

Height: 4 FT 11 IN Weight 160 LBS

Are you taking any current medications? ☐ Yes ■ No

Medication & Directions: _____

Reason prescribed: _____ Prescriber _____

Medication & Directions: _____

Reason prescribed: _____ Prescriber _____

Medication & Directions: _____

Reason prescribed: _____ Prescriber _____

Medication & Directions: _____

Reason prescribed: _____ Prescriber _____

## List of Medications ineffective in past:

Medication & Directions: _____

Reason prescribed: _____ Prescriber _____

Medication & Directions: _____

Reason prescribed: _____ Prescriber _____

Do you use any of the following? Answer specifics frequency, quantity, form of use, start age/how long, if sober for how long and relapse reasons if any, etc.

Caffeine ☐ Yes ☐ No

How many cups a day_____

Smoke ☐ Yes ☐ No ☐ Never

Passive _____

Tobacco ☐ Yes ☐ No ☐ Never _____

Alcohol ☐ Yes ☐ No ☐ Never

_____

Drugs ☐ Yes ☐ No ☐ Never

_____

Family History

Drugs ☐ Yes ☐ No If yes, who? _____

Alcohol ☐ Yes ☐ No If yes, who? _____

Pharmacy Name: Vons Phone 9097487788

Cross Streets/Address Orange st City Redlands

# Loma Linda Psychiatric Medical Group

Patient's Name Madden little Date of Visit: _____

| | Yes | No |
|---|---|---|
| Do you have thoughts that bother you or make you anxious and that you can't get rid of regardless of how hard you try? | | |
| Do you have any tendency to keep things extremely clean or wash your hands very frequently, more than other people you know? | | X |
| Do you check things over and over to excess? | | X |
| Do you have to straighten, order, or tidy things so much that it interferes with other things you want to do? | | X |
| Do you worry excessively about acting or speaking more aggressively then you should? | | X |
| Do you have great difficulty discarding things even when they have no practical value? | | X |

Answer each question by circling the appropriate number next to it.

| **Activity** | **Score** | | | | |
|---|---|---|---|---|---|
| 1. How much of your time is occupied by obsessive thoughts? | None 0 | < 1 hr/day 1 | 1-3 hr/day 2 | 3-8 hr/day 3 | > 8 hr/day 4 |
| 2. How much do your obsessive thoughts interfere with functioning in your social, work or other roles? | None 0 | Slightly 1 | Definitely, but manageable 2 | Substantially 3 | Extremely 4 |
| 3. How much distress do your obsessive thoughts cause you? | None 0 | Mild 1 | Moderate 2 | Severe 3 | Near constant 4 |
| 4. How much of an effort do you make to resist the obsessive thoughts? | Always 0 | Most of the time 1 | Sometimes 2 | Often 3 | Never 4 |
| 5. How much control do you have over your obsessive thoughts? | Complete control 0 | Much control 1 | Some control 2 | Little control 3 | No control 4 |
| 6. How much time do you spend performing compulsive behaviors? | None 0 | < 1 hr/day 1 | 1-3 hr/day 2 | 3-8 hr/day 3 | > 8 hr/day 4 |
| 7. How much do your compulsive behaviors interfere with functioning in your social, work or other roles? | None 0 | Slightly 1 | Definitely, but manageable 2 | Substantially 3 | Extremely 4 |
| 8. How anxious would you become if you were prevented from performing your compulsive behaviors? | No anxiety 0 | Mild anxiety 1 | Moderate anxiety 2 | Prominent anxiety 3 | Extreme anxiety 4 |
| 9. How much of an effort do you make to resist the compulsions? | Always 0 | Most of the time 1 | Sometimes 2 | Often 3 | Never 4 |
| 10. How much control do you have over the compulsions? | Complete control 0 | Much control 1 | Some control 2 | Little control 3 | No control 4 |

# Loma Linda Psychiatric Medical Group

Name: Madden little Date of Visit: _____

## Mood Disorder Questionnaire (MDQ)

### Section One

Answer Yes or No to each of the following questions:

| | Yes | No |
|---|---|---|
| 1. Have any of your blood relatives been diagnosed as "Manic-Depressive" or as having Bipolar Disorder? | ○ | ◉ |
| 2. Have you ever had far more energy than usual, slept very little, and engaged in activities that may have been risky or dangerous? | ○ | ◉ |
| **Has there ever been a period of time when you were not your usual self and…** | **Yes** | **No** |
| 1. You felt so good or hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble? | ○ | ◉ |
| 2. You were so irritable that you shouted at people or started fights or arguments? | ◉ | ○ |
| 3. You felt much more self-confident than usual? | ○ | ◉ |
| 4. You were much more talkative or spoke much faster than usual? | ○ | ◉ |
| 5. You got much less sleep than usual and found you didn't really miss it? | ○ | ◉ |
| 6. Thoughts raced through your head or you couldn't slow your mind down? | ○ | ◉ |
| 7. You were so easily distracted by things around you that you had trouble concentrating or staying on track? | ◉ | ○ |
| 8. You had much more energy than usual? | ○ | ◉ |
| 9. You were much more active or did many more things than usual? | ○ | ◉ |
| 10. You were much more social or outgoing than usual - for example, you telephoned friends in the middle of the night? | ○ | ◉ |
| 11. You were much more interested in sex than usual? | ○ | ◉ |
| 12. You did things that were unusual for you or that other people might have thought were excessive, foolish or risky? | ○ | ◉ |
| 13. You spent so much money that it got you or your family into trouble? | ○ | ◉ |

If you answered Yes to more than 1 of the questions in the first section, continue to Section Two.

### Section Two

Answer Yes or No to each of the following questions:

| | | |
|---|---|---|
| 14. Did any of these situations you said yes to ever happen during the same period of time? | ○ | ◉ |

Section Three

Choose only one response:

15. How much of a problem did any of these situations cause you (example, being unable to work, having family, money, or legal problems, getting into serious arguments or fights)?

- ( ) It has no problem
- (•) It was a moderate problem
- ( ) It was a minor problem
- ( ) It was a serious problem

## Patient Health Questionnaire (PHQ-9)

Circle one response for each of the following questions:

| Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | (•) | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | (•) | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | (•) |
| 4. Feeling too tired or having little energy | (•) | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | (•) |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | (•) | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | (•) |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | (•) | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or hurting yourself in some way | (•) | 1 | 2 | 3 |

If you circled any problems on this questionnaire, mark how difficult these problems have made it for you to do your work, take care of things at home, or get along with other people.

- ( ) Not difficult at all
- (•) Somewhat difficult
- ( ) Very difficult
- ( ) Extremely difficult

Loma Linda Psychiatric Medical Group

1001 E. Cooley Dr., Ste. 107, Colton, CA 92324

# Authorization for Use and/or Disclosure of Patient Health Information

Completion of this document authorizes the use and/or disclosure of your health information. Please read the entire document (both pages) before signing.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

| I hereby authorize: | To release information (specified below) to: |
|---|---|
| _____ (Health Care Provider / Organization to release information) | _____ (Health Care Provider / Organization to release information) |
| _____ (Address) | _____ (Address) |
| _____ (City, state, zip code) | _____ (City, state, zip code) |
| _____ (Phone Number) _____ (Fax Number) | _____ (Phone Number) _____ (Fax Number) |

I authorize the release of the following health information (select only one of the following):

☐ All health information about my medical history, mental or physical condition and treatment received; OR

☐ Only the following records or types of health information (including any dates):

_____

_____

_____

NOTE: The following types of information will not be released unless specifically authorized.

I specifically authorize the release of the following health information (initials required if any of the following boxes are checked):

☐ Mental Health Information Initial: _____

☐ Alcohol / drug treatment information Initial: _____

# Authorization for Use and/or Disclosure of Patient Health Information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE: The requested use or disclosure of my health information is for the following purposes:

(1) To provide and coordinate my health care treatment and services; and

(2) To improve the quality of health care that I receive.

EXPIRATION: This Authorization expires one year from the date of my signature unless a different date is specified here (date).

_____

REVOCATION: I understand that I may cancel this Authorization at any time, but I must do so by submitting my request for revocation to the Health Care Provider / Organization authorized to release the information. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

NOTICE OF RIGHTS AND OTHER INFORMATION:

I understand that I do not have to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment or eligibility for benefits.

I understand that I have a right to receive a copy of this Authorization.

I further understand that information disclosed by this Authorization, may be redisclosed (given to) another person or agency and may no longer be protected by federal confidentiality law (HIPAA). However, California law does not allow the person receiving my health information by this Authorization to disclose it, unless a new authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I have read both pages of this Authorization and agree to the use and disclosure of health information specified above.

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Patient's Legal Representative (if applicable) Date Signed

_____ _____

Print Name of Patient's Legal Representative Relationship to Patient

# Loma Linda Psychiatric Medical Group

1001 E. Cooley Dr., Suite 107, Colton, CA 92324

To whom it may concern,

I, _____, certify/consent that I am willing to be tapered off controlled substances. I understand that I will NOT receive a refill for my controlled substance and will work with my medical team to gradually taper off the controlled substance.

In the event that I do not wish to be tapered off from my controlled substance, I understand I would be discharged from Loma Linda Psychiatric Medical Group and will need to find another provider in my network.

These medications include Benzodiazepines, Stimulants and Sedative/Hypnotic medications.

7/14/25

_____ _____

Patient Name Date

_____

Patient Signature

# Loma Linda Psychiatric Medical Group

## Medication Consent Form

PATIENT NAME:

(Each provider responsible for this client's ongoing care must complete this form separately.)

INFORMATION RELEVANT TO CONSENT:

The undersigned provider for the client named below hereby certifies that he/she has supplied the following information regarding the administration of psychotropic medication to this client:

1. The nature of the client's medical condition;
2. The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;
3. The reasonable alternative treatments available, if any;
4. The type, range of frequency and amount (including the use of PRN orders), method (oral or injection), and duration of taking the medication;
5. The probable side effects of these drugs known to commonly occur, and particular side effects likely to occur with this particular client;
6. The possible additional side effects that may occur to clients taking such medication beyond three months: the client shall be advised that such side effects may include persistent involuntary movement of the face or mouth and might, at times, include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after the medications have been discontinued;
7. Printed information on medications given to client: ◯ YES ◉ Patient declined

_____ _____

DATE SIGNATURE OF PROVIDER

DATE AND PROVIDER INITIALS FOR EACH ADDITIONAL CLIENT CONSENT SIGNATURE BELOW CONSENT:

The client hereby acknowledges each time by signature below that:

1. I have participated to my satisfaction in the discussion and planning of my current medication services.
2. All the information above regarding the administration of psychotropic medications has been fully explained to me;
3. I understand this information and have no further questions at this time;
4. I understand that if I have questions after I have taken this medication, I will have an opportunity to discuss them with my prescriber;
5. I understand that nothing in this article prohibits a prescriber from taking appropriate action in an emergency;
6. I understand that I can withdraw this consent at any time by telling a member of the treating staff.

I DO CONSENT TO MY MEDICATION TREATMENT PLAN AND TO THE USE OF (list specific names of medications):

| MEDICATIONS | DATE | PATIENT SIGNATURE |
|---|---|---|
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