

*Please fill out form completely, download, and email to
colton@lomalindapsych.com

Loma Linda Psychiatric Medical Group

Patient Information Sheet

Last Name:		First Name:		MI:
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone:	Cell Phone:	
Marital Status: <input type="checkbox"/> Minor <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorce <input type="checkbox"/> Widowed		Social Security #:	Driver's License #:	
Home Address:				
Language:	Religion:	Race/Ethnicity: <input type="checkbox"/> African American/Black <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other		
EMERGENCY CONTACT INFORMATION				
Last Name:		First Name:		
Relationship to Patient:			Contact #:	
PRIMARY INSURANCE INFORMATION				
Primary Insurance Name:				
Primary Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:			Date of Birth:	
Subscriber's ID Number:		Group #:	C.D.L. #:	
Employer's Name:				
SECONDARY INSURANCE INFORMATION				
Primary Insurance Name:				
Primary Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> 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.

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 you 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: _____

Date: _____

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: _____

Date: _____

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: _____

Relationship to Patient: _____

Guardian's Signature: _____

Date: _____

Loma Linda Psychiatric Medical Group

Patient Acknowledgement of Notice of Privacy Practices

I, _____,
(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: _____ Date: _____

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: _____

Date: _____

Assessment Information

Patient Name: Last Name First Name Full Middle Name Nickname

Patient Address: 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):

Table with 4 columns: Name, Age, Sex, Relationship. Rows 1-6.

Significant others outside of home:

Table with 5 columns: Name, Age, Sex, Relationship, Town/State of Residence. Rows 1-5.

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SYMPTOMS IDENTIFICATION and HEALTH HISTORY

PATIENT'S NAME _____

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▶				
	0	1	2	3	4
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▶				
	0	1	2	3	4
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 _____

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Patient's name: _____

Height: _____ FT _____ IN Weight _____ 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: _____ Phone _____

Cross Streets/Address _____ City _____

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Patient's Name _____ 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?		
Do you check things over and over to excess?		
Do you have to straighten, order, or tidy things so much that it interferes with other things you want to do?		
Do you worry excessively about acting or speaking more aggressively than you should?		
Do you have great difficulty discarding things even when they have no practical value?		

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: _____ 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?		
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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: _____ (Health Care Provider / Organization to release information) _____ (Address) _____ (City, state, zip code) _____ (Phone Number) (Fax Number)	To release information (specified below) to: _____ (Health Care Provider / Organization to release information) _____ (Address) _____ (City, state, zip code) _____ (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).

REVOCAION: 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.

Patient Name

Date

Patient Signature

