L. David Willison IV, M.D., Ph.D.

10850 Wilshire Blvd., Suite 850
Los Angeles, CA 90024
Cell: (415) 412-4613
Office Fax: (310) 667-7974

ADULT MEDICAL SCREENING

Patient Information

NAME:	DATE OF BIRTH: ____/____/____
SOCIAL SECURITY #:	
Address:	
Home phone:	Work phone:
Fax:	Mobile phone:
Occupation:	Email:
Marital Status:	Educational level:
Emergency Contact:	

Chief Complaint

(SPECIFY ONSET AND DURATION):

Personal Medical History

Do you receive regular medical care from a physician or clinic? ☐ NO ☐ YES

If yes, please provide the following information:

Name of physician or clinic:

Address:

CURRENT MEDICATIONS:

MEDICATION ALLERGIES: ☐ NO ☐ YES.
OTHER:

Have you ever had any of the following:

Birth Defects	☐ NO ☐ YES	Peptic (Stomach) Ulcers	☐ NO ☐ YES
Broken Bones	☐ NO ☐ YES	Colitis	☐ NO ☐ YES
Drug Poisoning	☐ NO ☐ YES	Rheumatic Fever	☐ NO ☐ YES
Injuries	☐ NO ☐ YES	Tuberculosis	☐ NO ☐ YES
Severe Cuts or Lacerations	☐ NO ☐ YES	Gonorrhea	☐ NO ☐ YES
Asthma	☐ NO ☐ YES	Syphilis	☐ NO ☐ YES
High Blood Pressure	☐ NO ☐ YES	Meningitis or Encephalitis	☐ NO ☐ YES
Diabetes	☐ NO ☐ YES	Epilepsy	☐ NO ☐ YES
Cancer	☐ NO ☐ YES	Headaches	☐ NO ☐ YES
Thyroid Disease	☐ NO ☐ YES	Stroke	☐ NO ☐ YES
Other Hormone Problem	☐ NO ☐ YES	Head Injury	☐ NO ☐ YES
Alcoholism	☐ NO ☐ YES	Concussion	☐ NO ☐ YES

If yes, please explain (continue on the back):

Have you had any other disease? ☐ NO ☐ YES If yes, explain:

What is your current weight (estimate if you do not know exactly)?

What is the most you have ever weighed? lbs. When?

Can you explain any recent weight loss or weight gain?

Have you ever had to be hospitalized? ☐ NO ☐ YES If yes, complete the following:

Year	Doctor's Name	Name of Hospital

Have you ever had surgery , or been advised to have surgery? ☐ NO ☐ YES If yes, complete the following:

Year	Doctor's Name	Name of Hospital	Name of Operation or Procedure

Do you have Hay Fever or food allergies?

Have you recently had any of the following tests? When and why?

Physical Exam	☐ NO ☐ YES:	
Blood Tests	☐ NO ☐ YES:	
Chest X-ray	☐ NO ☐ YES:	
Electrocardiogram (E KG)	☐ NO ☐ YES:	
Brain Scan (MRI, CT)	☐ NO ☐ YES:	
EEG	☐ NO ☐ YES:	

Have you ever used the following and how much do you currently consume?

Coffee (cups/day)	☐ NO ☐ YES:	Aspirin	☐ NO ☐ YES:
Cigarettes (packs/day)	☐ NO ☐ YES:	Laxatives	☐ NO ☐ YES:
Marijuana (joints/day)	☐ NO ☐ YES:	Alcohol (amount and types used daily)	☐ NO ☐ YES:
Vitamins	☐ NO ☐ YES:		
Sleeping Pills	☐ NO ☐ YES:		

Have you ever used any of the following? (Circle the ones used)

Celexa	Prozac	Luvox	Paxil	Zoloft
Wellbutrin	Remeron	Serzone	Effexor	Lexapro
Buspar	Dilantin	Tegretol	L-Dopa	Cogentin
Lithium	Depakote	Topamax	Neurontin	Lamictal
Valium	Librium	Tranxene	Dalmane	Klonopin
Ativan	Restoril	Xanax	Serax	Halcion
Anafranil	Sinequan	Tofranil	Elavil	Pamelor
Haldol	Prolixin	Trilafon	Navane	Stelazine
Orap	Loxitane	Moban		
Thorazine	Mellaril	Serentil		
Zyprexa	Risperdal	Seroquel	Geodon	Clozaril
Abilify	Phenobarbital	Other barbiturates:		
Amphetamines	Ritalin	Dexedrine	Other stimulants:	
Heroin	Codeine	Methadone	Percodan	Dilaudid
Talwin	Darvon	Demerol		
Quaaludes	Ambien	Sonata	Other sedatives:	
Cocaine	Glue/inhalants			

Please detail periods of use, dosages, reasons for use, and reason for discontinuation of the above (continue on reverse).

Personal Psychiatric History

Have you ever received any previous psychiatric or psychological evaluation or treatment? ☐ NO ☐ YES If yes, complete the following (continue on back):

Year	Doctor	Clinic or Hospital	Reason	Medication Used (if any)

Have you ever attempted suicide? ☐ NO ☐ YES If yes, please describe when, how, what happened?

Family History

Please describe any family history of medical illnesses (such as cancer, hypertension, diabetes, neurological disorders):

Please describe any family history of mental health problems, such as depression, manic-depression (bipolar), anxiety, schizophrenia, suicides, substance use, learning disorders, autism:

Review of Your Current Health

Do you have any of the following? (Please circle)

Unusual excessive thirst	Skin problem
Weight loss or weight gain	Urine problems, blood in urine
Weakness or tiredness	Joint pain
Thyroid problem, goiter	Lumps anywhere
Shortness of breath at night or with exercise	Double vision or poor vision
Cough or wheeze	Difficulty hearing
Chest pain	Fainting spells / blackout spells
Palpitation or heart fluttering	Convulsion
Swelling of hands or feet	Trouble sleeping
Indigestion, gas, heartburn	Sexual problems
Spitting up blood	Depression
Vomiting / vomiting blood	Problems with memory, thinking, or concentration
Stomach pain or stomach ulcer	Suicidal thoughts
Diarrhea	Auditory hallucinations
Constipation	Visual hallucinations
Blood in stool	
Change in appetite or eating habits	

Please describe on the reverse any of the positive answers above.

FOR WOMEN ONLY:

Date your last menstrual period began:	Number of pregnancies:
Number of children born alive:	Number of therapeutic abortions: .
Number of miscarriages or stillbirths:	Have you had a Pap smear within the last year? ☐ NO ☐ YES
Do you use any contraceptive method?	☐ NO ☐ YES If yes, which?
Do you examine your breasts for lumps?	☐ NO ☐ YES

PATIENT'S SIGNATURE: DATE: _____/_____/_____

L. David Willison IV, M.D., Ph.D., APC
Adult, Child, and Adolescent Psychiatrist
EIN: 47-4629112
NPI: 1104070010

10850 Wilshire Blvd., Suite 850
Los Angeles, CA 90024
Phone: (415) 412-4613
Fax: n/a
L.David.Willison.MD.PhD@gmail.com

Professional Fees & Policies

Professional Fees:

- Initial Appointment (1.5 to 2 hours): $1700
- Follow-up Appointment (40 to 60 min.): $850
- Follow-up Appointment (20 to 30 min.): $550

Payment is due at the end of each appointment.

Cancellation Policy:
I charge my full fee for an appointment if it is cancelled within 48 hours.

Phone, Text and Email Policy:

- Brief communication (under 5 minutes) is not typically billed.
- Longer emails and email exchanges, texting, or phone communication between appointments including, but not limited to, medication refills, side effects, coordination of care with other providers, etc. will be pro-rated and billed in 15-minute increments according to my 1-hour appointment rate (currently $200 per 15 min.).
- Report writing, communication with other providers, and any other requested professional work will be similarly pro-rated and billed.

Legal Work:
These services are billed at $1600 per 60 min. (pro-rated in 15-minute increments) including case preparation, travel time, waiting time, etc.

Travel Policy:
I am available to travel to patient's homes for appointments. The total round trip travel time will be pro-rated against my 1-hour appointment rate in 15-minute increments and billed in addition to my regular appointment fee.

Fee Changes:
My professional fees will increase over time (usually every 12 months). I will inform you prior to any fee changes.

_____ _____
Patient's Signature Date

_____ _____
Parent's/Guardian's Signature (If Applicable) Date

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Credit Card Information

- **Card Number:**

  _____

- **Expiration Date:**

  ____/_____

- **CVV/Code:**

  _____

- **Billing Zip or Postal Code:**

  _____

_____ _____
Patient's Signature Date

_____ _____
Parent's/Guardian's Signature (If Applicable) Date

HIPAA Notice of Privacy Practices

Acknowledgement of Receipt

L. David Willison IV, M.D., Ph.D.
10850 Wilshire Blvd. Suite 850
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90024
c. (415) 412-4613
f. (310) 667-7974

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices which is attached.

A copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

O Parent or guardian of minor patient

O Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact me at the above address.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re- disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [*Participants in organized health care arrangements only should add*: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. If you are currently an enrollee of a health plan, we may receive payment for communications to you in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of your covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. We will not accept any payment for other marketing communications without your prior written authorization unless you have a chronic and seriously debilitating or life-threatening condition and we are making the communication in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. If we make these types of communications to you while you have a chronic and seriously debilitating or life-threatening condition, we will tell you who is paying us, and we will also tell you how to stop these communications if you prefer not to receive them. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization, and we will disclose whether we receive any payments for any marketing activity you authorize.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and Administrative Proceedings.We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. [Add if you use an electronic health record: If your written request clearly, conspicuously and specifically asks us to send you or some other person or entity an electronic copy of your medical record, and we do not deny the request as discussed above, we will send a copy of the electronic health record as you requested, and will charge you no more than what it cost us to respond to your request.]

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have

the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. **Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. [*For practices with websites add*: We will also post the current notice on our website.]

E. **Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100 San
Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf . You will not be penalized for filing a complaint.