LifeStance HEALTH

490 Post St. Suite 1043
San Francisco, CA 94102
PH: 415-296-5290
Fax: 415-296-5299
www.lifestance.com

NEW PATIENT REGISTRATION FORMS

- Please complete this form in its entirety. No further paperwork will be required at your initial appointment.
- Page 2 asks for your primary care provider's contact information (if you are currently seeing one). This is required so that your LifeStance Health provider can collaborate with them as appropriate. If you do not have their full contact information, please obtain it via web search.
- Page 3 explains our payment policy and Patient Portal.

PATIENT DEMOGRAPHIC INFORMATION

FIRST NAME:_____ LAST NAME:_____
DATE OF BIRTH:____/____/_____ (MM/DD/YYYY) SEX:_____
ADDRESS:_____ CITY:_____
STATE:_____ ZIP:_____ CELL PHONE: (_____)-_____-_____
EMAIL ADDRESS:_____

EMERGENCY CONTACT: _____
RELATIONSHIP:_____
EMERGENCY CONTACT PHONE NUMBER :(_____)-_____-_____

INSURANCE INFORMATION

PLEASE REFER TO YOUR INSURANCE CARD FOR THE FOLLOWING INFORMATION

INSURANCE CARRIER: _____ INSURANCE ID: _____

INSURANCE PHONE NUMBER: (_____)-_____-_____

DO YOU HAVE MEDICARE OR MEDI-CAL? _____

LifeStance Health, Inc.
Authorization to Release Confidential and Protected Health Information

Client Name (please print)**:** _____ **DOB** _____

In accordance with federal rules, 42 CFR part 2 (Confidentiality of Substance Use Disorder Patient Records) and 45 CFR part 164 (Health Insurance Portability and Accountability Act of 1996), I authorize LifeStance Health, Inc. to release the information about me as indicated below. I understand information about any of the following may be included in the release: behavioral health, sexuality and reproductive health, HIV/AIDS, sickle cell anemia, communicable diseases, drug and alcohol use, and treatment for a substance use disorder.

Name of individual(s) or entity(ies) to receive the information indicated below:
Name _____
Address _____ **City/State/Zip** _____
Phone _____ **Fax** _____

Type of Records Authorized to Be Released

☐All information maintained in my record ☐Only the types of information/records checked below (check all that apply)

☐Attendance ☐Billing records ☐Clinical assessment(s) ☐Diagnosis lists ☐Demographics
☐Discharge summary ☐DMV/DOL information ☐Laboratory results ☐Medication history/orders ☐Parole/Probation info
☐Physician/Therapist summaries ☐Progress notes/summaries ☐Psychiatric evaluations ☐Psychological testing
☐Service/Treatment plans ☐Status report(s) ☐SUD evaluation and recommendations
☐Other (must specify) _____

Time Period (check only one)
☐All admissions ☐Most recent admissions ☐Dates _____ to _____

Purpose for the disclosure:
☐ Coordination of care ☐ Payment or billing ☐ Probation or Legal Coordination
☐ Other: _____

Re-disclosure
I understand that information disclosed based on this Authorization, except for information about a substance use disorder, may be re-disclosed by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR part 164). Records about a substance use disorder will continue to be protected under federal rules following disclosure and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in the relevant rules (42 CFR part 2).

Prohibition on Conditioning of Authorizations
I understand that I cannot be required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. LifeStance Health Inc. may not refuse to treat me if I refuse to sign this Authorization, unless this Authorization is necessary for my participation in a research study or the purpose of the treatment is to provide information to the individual/entity identified in this Authorization.

Expiration and Right to Revoke (Cancel)
I understand that I may revoke this Authorization at any time, except to the extent that information has already been disclosed or obtained in reliance on it. The revocation must be in writing. If not revoked, this Authorization will expire 90 days after completion of course of treatment and/or payment in full for services unless an earlier date is specified here:_____.

Authorization
My signature below means I understand and accept the terms of this Authorization. A copy of this Authorization (including a fax) is as valid as the original. I have a right to receive a copy of the signed Authorization.

Signature of individual or authorized representative: _____ **Date:** _____

Name of authorized representative (please print): _____ **Relationship:** _____

NOTICE TO RECIPIENTS
If the information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

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ACKNOWLEDGMENT SIGNATURE FORM

Please initial to the left to acknowledge you've read and agree to each policy, then sign at the bottom.

____ ***Authorization to release patient health information for treatment, billing or healthcare operations. (Available to view and print on our website)***

____ ***Acknowledgement of receipt of Notice of Privacy Practices and Policies from Pacific Coast Psychiatric Associates. (Available to view and print on our website)***

____ ***Acknowledgment of receipt of Office Policies and Procedures from Pacific Coast Psychiatric Associates. (Available to view and print on our website)***

PAYMENT POLICY

____ ***I understand that payment is due at the time of each service by credit card. Please note that this includes CoPayments, CoInsurance and Deductibles.***

____ ***If we contract with your insurance company, we will submit statements directly to the insurer on your behalf, but if any amount is declined or applied to your deductible, we will bill you the unpaid amount. I agree to make payment by the next appointment, or within 30 days if there is no appointment scheduled before.***

____ ***If there is any amount owed to us for any reason that remains unpaid after 60 days from the date first billed, you authorize us to charge this amount to your credit card on file without further notice.***

____ ***The Credit card on file will be automatically charged a $175.00 fee for any late cancellations (less than 48 business hours notice) or no-shows, with no exceptions.***

PATIENT PORTAL

____ ***I understand that information submitted via the portal will NOT BE REVIEWED UNTIL MEETING IN PERSON WITH MY DOCTOR. I will therefore contact my provider directly for any urgent matters.***

I have reviewed this form and I agree with all policies and procedures as described above.

Patient Printed Name_____

Patient Signature_____ **Date** _____

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Important Information

Please initial at the bottom to acknowledge you've read and agree to each policy.

● Please also note that LifeStance Health has a 48 business hours cancellation policy. Once your appointment is scheduled, you will be charged $175 if you fail to cancel your appointment with adequate notice or do not show up to your appointment.

● Please try to arrive to your appointment on time. Your first appointment will be about 45 minutes in duration. Please note that if you arrive late, the appointment time cannot not be extended as your psychiatrist or therapist has a full schedule.

● Please note that the entire evaluation may not be completed in just one session. You and your psychiatrist or therapist will schedule a second session to complete the evaluation if necessary.

● During psychiatric evaluations, your psychiatrist will ask you about current and past psychiatric symptoms, Mental Health treatment history, current medication regimen, history of Alcohol and Drug use and about any current stressors you might be dealing with. At the end of the evaluation process, your psychiatrist will provide you with feedback, including their thoughts about a diagnosis as well as treatment recommendations.

● Please note that although all of our psychiatrists do provide psychotherapy treatment, depending on their caseload at the time of your evaluation, they may not be able to provide you with psychotherapy themselves. If that is the case, they will provide you with the appropriate referrals.

● Please also note that your psychiatrist may not be able to prescribe you medication on the first visit. Prescribing psychiatric medications on the first visit will be evaluated by your psychiatrist on a case by case basis. If that is a concern of yours, please bring this up when you first see your psychiatrist.

I have read and agree to the above policies and procedures: _____ (your initials)

PLEASE MAIL OR FAX THIS FORM AND WE WILL CONTACT YOU TO SCHEDULE AN APPOINTMENT. We look forward to meeting with you and providing you with excellent service!