Katherine Watkins, M.D., M.S.H.S.
2999 Overland Avenue, Suite 201
Los Angeles, CA 90064

PATIENT REGISTRATION

Name: _____ Consultation date: _____

Date of birth: _____ Gender: _____

Preferred phone: _____ [ ] cell [ ] home [ ] work [ ] other

Permission to leave detailed messages on this phone? [ ] yes [ ] no

Other phone: _____ [ ] cell [ ] home [ ] work [ ] other

Permission to leave detailed messages on this phone? [ ] yes [ ] no

Mailing address: _____
Street address, if different: _____
Email address: _____

Emergency contact: _____ Phone: _____

Relationship: _____

Past medical history: _____

Allergies: _____

Primary care MD: _____ Phone: _____

Address: _____

Pharmacy: _____ Phone: _____

NOTICE OF PRIVACY PRACTICES

Information about patients remains confidential whenever possible.

Dr. Watkins will request either written or verbal consent for Authorization for Release of Information from the patient for any disclosure of patient information.

Dr. Watkins will request permission to remain in contact with the primary care physician or other key healthcare providers, to better coordinate the patient's care.

Dr. Watkins will provide invoices for rendered services, and receipts when payment is made. These forms will have *diagnosis codes* and *description of services* rendered. (Insurance companies generally require documentation with this information for out-of-network claims.)

There are rare instances when the law may require a health professional to release information about a patient without the patient's authorization, such as:

1. If the physician has reason to believe that the patient poses a direct threat of imminent harm to self or others
2. If the physician has reason to believe that abuse or neglect of a child, elder, dependent, or disabled person is taking place
3. If the physician is ordered by a court to use or disclose information in the course of a judicial or legal proceeding.

I have read and agree to the Notice of Privacy Practices detailed above:

Signature:_____ Today's date:_____

Printed name:_____ Date of birth:_____

Relationship to patient (self, parent, legal guardian):_____

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OFFICE POLICIES

Appointments and Cancellations

- I understand that there may be times when you will need to change an appointment. I request 24 hours advance notice of cancellation or else I will need to charge you for that session. Please be aware that insurance companies will not reimburse for a missed appointment.

Fees and Payments

- Payment is expected at the time of the visit. I accept check or cash.
- Any costs for collection or legal processes necessary to collect unpaid balances will be the patient's responsibility.

Insurance Policies

- While I do not contract with insurance companies, I do assist my patients by providing the paperwork necessary to submit into their insurance carriers for reimbursement. I am considered an "out-of-network" physician for PPO insurance plans. Please contact your insurance company for details on whether they reimburse policy holders for out-of-pocket payment to noncontracted providers. Practicing this way allows me to focus on providing my patients with more substantial and longer sessions than many other psychiatrists.

Contact Policies

- During normal business hours, patients should call my office at 310-470-1534. For urgent matters outside of business hours, patients may contact me at 310-871-2406.
- If a situation requires immediate attention, please call 911 or go to the nearest hospital emergency room.

I have read and agree to the Office Policies detailed above:

Signature:_____ Today's date:_____

Printed name:_____ Date of birth:_____

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INFORMED CONSENT REGARDING THE USE OF PHYSICIAN-PATIENT ELECTRONIC COMMUNICATION, INCLUDING EMAIL AND TEXT MESSAGING, TO TRANSMIT PROTECTED HEALTH INFORMATION

I offer my patients the opportunity to communicate with me using electronic communication methods, including by email and text messaging. However because the privacy of electronic communication cannot be guaranteed, please read and sign this consent form acknowledging that you understand the risks inherent with physician-patient electronic communication and consent to its use.

Use of electronic communication is meant to be an **adjunct** to regular appointments and verbal communication. While I will do my best to respond to electronic communication within 48 hours, (and generally will respond the same day) **electronic communication should not be used for emergency or urgent communication**, as I cannot guarantee that I will be able to read and respond to the communication in a timely manner. In addition, email is not always instantaneous and sometimes may arrive hours or even days after it is sent.

Risks of Using Electronic Communication Methods

There are several risks to using electronic communication methods. They include, but are not limited to, the following:

- The privacy and security of electronic communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system. Therefore I suggest you use only your personal computer to communicate electronically with me.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.

Conditions of using email

I will use reasonable means to protect the security and confidentiality of any electronic communication sent and received. My email and phone are password protected and only I know the password. However, because of the risks outlined above, I cannot guarantee the

security and privacy of electronic communication. Thus, you must consent to the use of email or text messaging to transmit protected patient information, including mental health or substance abuse information. Consent to the use of email includes agreement with the following conditions:

- Emails to or from you concerning diagnosis or treatment may be printed in full and made part of your medical record.
- It is your responsibility to inform me of any types of information you do not want sent using electronic communication methods.
- Although I endeavor to read and respond promptly to electronic communication, I cannot guarantee that any particular electronic communication will be read and responded to within any particular period of time. Thus, do not use email for medical emergencies or other time-sensitive matters.
- If you have not received a response within a reasonable period of time, it is your responsibility to follow up with me to determine whether I received the communication and when I will respond. I am not responsible for information loss due to technical failures associated with either your or my software or internet service provider.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of electronic communication methods (email and/or text messaging) to communicate between the physician and me, and understand that this consent applies to the communication of mental health and substance abuse diagnosis and treatment information. I consent to the conditions outlined herein. I acknowledge Dr. Watkins' right to, upon the provision of written notice, withdraw the option of communicating through email and/or text messaging. Any questions I may have had were answered.

Signature:_____ Today's date:_____

Printed name:_____

Katherine E. Watkins, M.D., M.S.H.S., A Professional Corporation
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