Arman Danielyan, M.D.

Diplomate, American Board of Psychiatry & Neurology

Child, Adolescent & Adult Psychiatry and Psychopharmacology

Tel: (925) 385-8574

Fax: (925) 307-5276

info@baypsychiatry.com

www.baypsychiatry.com

Registration form

Patient information

Patients Name: First _____; Last _____

DOB: _____; Age _____; Weight: _____; Height: _____; Sex: Male / Female

Address: Street _____; City: _____; State: _____; Zip: _____

Email: _____; Home Phone: _____; Cell phone: _____

Social Security Number: _____; Highest Level of Education: _____

Employer name: _____; Position: _____; Work hours: _____

How long at this job: _____; Ethnicity: _____; Religion:_____

Marital Status: _____; Years together: _____; Spouses name: _____; Children;_____

Emergency Contact

Name: _____; Relationship: _____

Address: _____; Phone numbers: _____

Primary Care Provider

Name: _____; Address:_____

Tel: _____; Fax: _____; Email: _____

Guarantor:

Name: _____: DOB: _____; SS#: _____

Health insurance: _____; ID#: _____;

Group ID#: _____; Insurance Contact info: _____

_____ _____ _____

Patient (Print Name) **Signature** **Date**

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PRESENTING PROBLEM

Please describe the main problem(s) you are seeking this consultation for. Describe when did it start, any known stressors, the progression, severity, current status.

_____

_____

_____

_____

_____

_____

CURRENT PSYCHIATRIST: _____
Name Contact information

CURRENT THERAPIST:_____
Name Contact information

PAST PSYCHIATRIC HISTORY

- Psychiatric hospitalizations:

Year	Hospital	Reason	Duration

- Intensive Outpatient Programs or Partial Hospitalization Programs

Year	Hospital/Program	Reason	Duration

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- Psychotherapy:

Year	Type of therapy (CBT, DBT, IPP, Family, MFT, other)	Duration	Was it helpful?

- History of suicide attempt. Please describe details, if any.

MEDICAL HISTORY.

Please describe any known medical problems, current or past. Include surgical history.

Any known history of Heart problems? *Yes / No.* If yes, please describe:

Any known history of Seizures or Traumatic Brain Injuries? *Yes / No.* If yes, please describe:

Allergies:_____

- Medications current:

Name	Dose	Frequency	For how long	Side effects	Helpful?

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- Medications past:

Name	Max Dose	Frequency	For how long	Side effects	Helpful?

SUBSTANCE USE HISTORY

Please list the names of any substances used, currently or in the past

Name	Current?	Frequency	For how long
Cigarettes			
Alcohol			
Marijuana			
Hallucinogens			
Opiates			
Other:			
Other:			

Any DUI? Yes (how many):_____; No

FAMILY PSYCHIATRIC HISTORY

Please list any known psychiatric diagnoses in family members. Please also list any family history of attempted/completed suicides. Also include any known family history of substance abuse.

Relationship	Diagnoses	Medications used
Father		
Mother		
Brother		
Sister		
Maternal GM		
Maternal GF		
Maternal Aunt/Uncle		
Paternal GM		

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SOCIAL HISTORY

About yourself:

Education: _____

Hobbies: _____

Sports: _____

Socially active vs. withdrawn: _____

Church involvement: _____

Traumas

History of being sexually, physically or emotionally abused:

_____
_____
_____

Sexual

Are you sexually active: Yes / No: _____

Type of protection used: _____

Other: _____

Legal

Any history of being arrested, convicted; any jail/prison time:

_____
_____
_____

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Review of Systems

GENERAL	Yes	No	Please explain further.
			Do you have allergies to medications? If so, please list them and the reaction they caused.
			Recurrent fever or chills?
			Unintentional weight loss?
			Recurrent fatigue or malaise?
SKIN	**Yes**	**No**	
			Rash or skin color changes?
			Jaundice (yellowing of the skin or eyes)?
			Moles that are changing color or size?
HEENT	**Yes**	**No**	
			Headaches that are new or changing in frequency or severity?
			Hearing changes?
			Visual changes? (If yes, are you seeing an eye doctor?)
			Non-healing mouth sores?
			Swollen glands or neck lumps?
			Hoarseness?
RESPIRATORY	**Yes**	**No**	
			Cough that is chronic, produces phlegm or is changing?
			Difficulty breathing?
			Wheezing?
			Do you smoke or are you exposed to 2nd hand smoke?
CARDIAC	**Yes**	**No**	
			Chest pain or pressure?
			Shortness of breath with normal activity?
			Difficulty breathing when lying flat?
			Shortness of breath that wakes you from sleep?
			Palpitations (sensation of heart beating in your chest)?
			Swelling in the ankles?
Gastrointestinal	**Yes**	**No**	
			Difficult or painful swallowing?
			Recurrent nausea or vomiting?
			Recurrent diarrhea or constipation?
			Recurrent abdominal pain or cramping?
			Bloody or black bowel movements?
GENITOURINARY	**Yes**	**No**	
			Pain with urination?
			Dark or reddish urine?
			Involuntary loss of urine?

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			Decreased force of urine stream or difficulty starting urine?
			Problems achieving or maintaining erections?
MUSCULOSKELETAL	**Yes**	**No**	
			Painful joints? (If yes, which ones?)
			Swollen joints?
			Morning joint stiffness? (If yes, how long does the stiffness last?)
NEUROLOGIC	**Yes**	**No**	
			Frequent dizziness?
			Fainting?
			Weakness in arms or legs?
			Numbness or tingling in arms or legs?
			Un-coordination or loss of balance?
INFECTIONS	**Yes**	**No**	
			Do you feel you are at risk for HIV infection?
			Have you ever been exposed to or treated for tuberculosis?
			Have you ever had a blood transfusion?
			Recurrent night sweats?
			Sexually transmitted diseases?
ENDOCRINE	**Yes**	**No**	
			Frequent urination? (If yes, how many times do you get up at night to urinate?)
			Increased thirst?
			Skin, hair or fingernail changes?
			Hot or cold intolerance?
GYNECOLOGIC (female)	**Yes**	**No**	
			Are you still having menstrual periods? If **YES**, when was your last menstrual period?____
			Vaginal bleeding differing from your regular menstrual flow?
			Abnormal vaginal discharge?
			Painful intercourse?
			New breast lumps?
			Abnormal pap smears? Date of last pap smear?
			Abnormal mammograms? Date of last mammogram?
PREVENTION SCREENING	**Yes**	**No**	
			Do you exercise on a regular basis (at least 3 times per week)?
			Do you believe you eat a varied, balanced diet?
			Have you had a tetanus shot within the last 10 years? If so, when?
			Have you ever had the pneumonia vaccine (Pneumovax)? If so, when?
			Have you ever had a sigmoidoscopy or colonoscopy? If so, when?
			Do you see any other doctors on a regular basis? If so, who and when?

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HIPAA Notice of Privacy Practices

I. **THIS DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND KEEP IT ON FILE FOR FUTURE REFERENCE. THIS APPLIES TO MINORS AND THOSE WHO HAVE LEGAL GUARDIANS.**

II. IT IS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

Protected Health Information (PHI) refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care. Examples of PHI include your name, address, birth date, age, phone number, diagnosis, medical records, and billing records. We are required by applicable federal and state law to maintain the privacy of your protected health information, and to give you this Notice of Privacy Practices that describes our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notification takes effect April 14, 2008 and will remain in effect until replaced. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice of Privacy Practices at any time. For more information about our privacy practices or for additional copies of this Notice, contact us.

For purposes of this Notice, the use of the word "we" or "I" should be taken to mean Dr. Arman Danielyan, M.D. and his entire office staff.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its HIPAA Privacy Rule (Rule), we are permitted to use and/or disclose your PHI for a variety of reasons. Except in specified circumstances, we are required to use and/or disclose only that minimum amount of your PHI necessary to accomplish the purpose for the use and/or disclosure.
Generally, we are permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, and for our normal health care operations. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization. However, the Rule provides that we are permitted to make certain other specified uses and/or disclosures of your PHI without your Authorization. The following information offers more descriptive examples of our potential use and/or disclosure of your PHI:

A. **Uses and/or Disclosures of PHI for Treatment, Payment, and Health Care Operations That Do Not Require Your Prior Written Consent:**
Your PHI may be used and disclosed without your consent for the following

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reasons:

1. **For treatment.** Your health information may be used to give you medical treatment or services. Your health information may be disclosed to pharmacists and their assistants, and other professionals involved in your care to put in place a treatment plan and to carry out that plan. For example, if you or your child has ADHD, the doctor, or office staff may need to clarify medication instructions with the pharmacy; obtain prior authorization for certain medications from insurance entities; tell the school nurse when to dispense medication. In some situations, your health information may be disclosed to other health care facilities or providers who will be treating you. For example, we may disclose health information about you to people outside of this office who provide follow-up care to you, such as physicians and in-patient treatment facilities.

2. **For health care operations.** Your PHI may be disclosed to facilitate the efficient and correct operation of this practice. Examples: Quality control - Your PHI might be used in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. Your PHI may also be provided to attorneys, accountants, consultants, and others to make sure of compliance with applicable laws.

3. **To obtain payment for treatment.** Your PHI may be used and disclosed to bill and collect payment for the treatment and services provided to you. Example: Your PHI might be communicated to your insurance company or health plan in order to get payment for the health care services that have been provided to you. Your PHI may also be provided to business associates, such as billing companies, claims processing companies, and others that process health care claims for this office.

4. **Appointment Scheduling/Reminders:** Unless you request that we contact you by other means, the Privacy Rule permits us to contact you by phone/ voice mail to schedule appointments and to leave appointment reminders.

5. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that this office attempts to get your consent after treatment is rendered. In the event that this office tries to get your consent but you are unable to communicate (for example, if you are unconscious or in severe pain) but is reasonable to assume that you would consent to such treatment if you could, your PHI may be disclosed.

B. **Certain Other Uses and Disclosures That Do Not Require Your Consent.** Your PHI may used and/or disclosed without your consent or authorization for the following reasons:

1. **When required by law:** we may use and/or disclose your PHI when existing law requires that we report information including each of the following areas:

2. **Reporting abuse, neglect or domestic violence:** we may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse,

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neglect, or domestic violence or the possible victim of domestic violence or the possible victim of other crimes.

3. **Child abuse:** Whenever we, in our professional capacity, have knowledge of or observe a child we know or reasonably suspect, has been the victim of child abuse or neglect, we must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if we have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional wellbeing is endangered in any other way, we may report such to the above agencies.

4. **Adult and domestic abuse:** If we, in our professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if we are told by an elder or dependent adult that he or she has experienced these or if we reasonably suspect such, we must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency. We do not have to report such an incident told to us by an elder or dependent adult if (a) we are not aware of any independent evidence that corroborates the statement that the abuse has occurred; (b) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and (c)) in the exercise of clinical judgment, we reasonably believe that the abuse did not occur.

5. **To avert a serious threat to health or safety**: we may use and/or disclose your PHI in order to avert a serious threat to health or safety. If you communicate to us a serious threat of physical violence against an identifiable victim, we must make reasonable efforts to communicate that information to the potential victim and the police. If we have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, we may release relevant information as necessary to prevent the threatened danger.

6. **Public health activities:** we may use and/or disclose your PHI to prevent or control the spread of disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food, dietary supplements, product defects and other related problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether or not you have a work-related illness or injury, in order to comply with Federal and state law.

7. **Health oversight activities**: we may use and/or disclose your PHI to designated activities and functions including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs.

8. **Judicial and administrative proceedings:** we may use and/or disclose your PHI in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.

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9. **Law enforcement activities:** we may use and/or disclose your PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death. § **Relating to decedents:** we may use and/or disclose the PHI of an individual's death to coroners, medical examiners and funeral directors.

10. **For specific government functions:** we may use and/or disclose the PHI of military personnel and veterans in certain situations. Similarly, we may disclose the PHI of inmates to correctional facilities in certain situations. We may also disclose your PHI to governmental programs responsible for providing public health benefits, and for workers' compensation. Additionally, we may disclose your PHI, if required, for national security reasons.

C. Uses and/or Disclosures of PHI Requiring Authorization

In any other situation not described in Sections IIIA and IIIB, your written authorization will be requested before using or disclosing any of your PHI. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocations will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. **Psychotherapy Notes:** we will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes we have made about our conversation during an individual, group, conjoint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

D. Uses and/or Disclosures Requiring You to Have an Opportunity to Object

We may disclose your PHI in the following circumstances if we inform you about the disclosure in advance and you do not object. We may use or disclose health information to notify or assist the notification of (including identifying or locating) a family member, your personal representative or another person responsible for our care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such use or disclosure.

However, in the event of your incapacity or emergency circumstances and you cannot be given an opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. We will disclose only health information that is directly relevant to the person's involvement in your healthcare. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

IV. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI).

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The HIPAA Privacy Rule grants you each of the following individual rights:

1. **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. (If you request copies, we will charge you $1.00 per page to locate and copy your health information, and postage if you want the copies mailed to you.) We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

2. **Right to Request an Amendment:** If you believe that your PHI is incorrect or incomplete, you may ask us to amend the information. This request must be made in writing, and it must explain why the information should be amended. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process;

3. **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. A request for a restriction must be put in writing. However, we are not required to agree to a restriction you request. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make. If we do agree to your request, we will put these limits in writing and abide by them except in emergency situations;

4. **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.) You must make your request in writing. It must specify how and/or where you wish to be contacted. We will accommodate all reasonable requests.

5. **Right to an Accounting:** You generally have the right to receive a list of disclosures of PHI for which you have neither authorization nor consent (see above for this section). This accounting will begin on 4/15/08 and disclosure records will be held for six years. On your request, we will discuss with you the details of the accounting process.

6. **Right to a Paper Copy:** You have the right to obtain a paper copy of this Notice of Privacy Practices from us upon request.

V. QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed

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at the end of this notice. You also may submit a written complaint to the Secretary of the U.S. Department of Health and Human Services. Upon request we will provide you with the address to file your complaint with the U.S. Department of health and Human Services. Any complaint you file must be received by us, or filed with the Secretary, within 180 days of when you know, or should have known, the act or omission occurred. We support your right to the privacy of your health information. We will not retaliate in any way if you make a complaint.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT PRIVACY PRACTICES:

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Dr. Arman Danielyan, M.D, 1655 N. Main Street, Suite 200, Walnut Creek, CA 94596.
Tel: 925-385-8574 or info@baypsychiatry.com.

VII. Effective Date: This Notice of Privacy Practices is effective April 15th, 2008

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HIPAA Notice of Privacy Practices Signature Form

I have received a copy of "HIPAA Notice of Privacy Practices".

_____ _____

Name of patient or responsible party Relationship to patient

_____ _____

Signature Date

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NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

_____ _____

Date Patient's Name (Type or Print)

_____

Patient's Signature

_____ _____

Date Patient Guardian's Name and Relationship (Type or Print)

_____

Patient's Representative's Signature

3515 Mt. Diablo Blvd, # 44. Lafayette, CA 94549

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Medication Treatment Consent Form

I, _____, hereby, as the patient/client, parent/legal guardian of _____ give permission to Dr. Arman Danielyan to prescribe medication(s) for my/my child's treatment. Dr. Danielyan has informed me of the nature of the treatment and has explained to me the reason for the use of medication, dosage, administration, as well as **risks, benefits and potential adverse events** associated with taking prescribed medications. Dr. Danielyan also discussed alternative treatment options available.

I understand that although Dr. Danielyan has explained the most common adverse events of this treatment to me, there may be other adverse events, and that I should promptly inform Dr. Danielyan or seek emergency care if there are any unexpected changes in my condition.

I attest that I am legally competent and have authority to provide consent for treatment. I understand that I may not be compelled to take this medication and that I may decide to stop taking it at any time. I also understand that although Dr. Danielyan believes that this medication will help me, there is no guarantee as to the results that may be expected.

On this basis, I consent to this treatment and authorize Dr. Danielyan or anyone authorized by him to administer above listed medication(s) at such intervals as he deems advisable.

_____ _____
Patient Date

_____ _____
Parent/Legal guardian signature Date

_____ _____
Treatment provider Date

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E-MAIL CONSENT FORM

IN A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911.

Information About Email Communication and Our Email Policies

You have asked to communicate with Dr. Arman Danielyan and his office staff via email. To do so with safety and confidence, you must understand and agree to our guidelines. Please read the following information about email communication and our email policies. If you have any questions about what you read, please ask us.

Following this information is an agreement intended to protect your confidentiality. If you understand our email policies and agree to adhere to them, please sign and date the form. If, at any time, you wish to discontinue email communication with this office, please submit your request in writing to us. By signing this email consent form you agree that:

- Email correspondence should be between the provider and an adult patient 18 years or older, or parent or legal guardian of a minor.
- Email communication is not a substitute for a face-to-face encounter with a physician.
- We will communicate with you via email only if you are an established patient. That means that we will communicate with one another only in the context of care that began with a face-to-face encounter.
- You should limit your email communication with us **to ask routine, non-urgent medical questions; to schedule an appointment; or to report a mild reaction to treatment.** You should **NOT** email you doctor regarding emergencies, as you should be aware that time-sensitive matters are not appropriate for email communication.
- You will not communicate by email about information or questions related to 1) highly sensitive subjects such as HIV/AIDS or STDs; 2) questions or problems of a sexual nature; 3) alcohol or drug dependence or treatment; 4) questions about mental health; or 5) lab results.
- You will include your name, home or mailing address and telephone number in the body of all email you send to your doctor's office to ensure that they have an alternate means of contacting you.
- You will fill in the subject line of each email to alert the doctors and their staff of the purpose of my message. (e.g., REFILL; QUESTION; APPOINTMENT; etc.)
- You will be responsible for following the medical advice the doctors convey to you by email.
- We will try to respond to email messages within 24 hours. However, there is no way to guarantee that this will occur, for a variety of legitimate reasons. If you do not get a response from this office within 24 hours, it is your (patient's) responsibility to contact us

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by telephone, mail, fax, or in person.

- We do not accept medication refill requests by email unless the request was preceded by a recent exam in the office. Even then, good medical practice may mean that it is necessary for you to be seen before we can refill your medication.
- It is our practice to make every effort to protect your confidential information in all communication, e.g., encryption, automatic logout. We acknowledge, however, that no email is 100% secure. Information, including email messages, stored on the computer hard drive, could be retrieved. We cannot guarantee against unknown privacy violations such as unauthorized access achieved by illegal activity.
- We will do our best to avoid technical problems. However, if a computer virus infiltrates our system, we cannot guarantee that we could prevent it from inadvertently passing to your computer.
- We are not responsible for e-mail messages that are lost due to technical failure during composition, transmission and/or storage.
- All email communication will be filed in your medical chart in the electronic medical records that we use.
- If you fail to adhere to our email policies, we will discontinue our communication with you via email and will limit our correspondence to more traditional means, such as the telephone and/or US mail.
- I agree to pay the doctor's fees for email communication that requires more than 10 minutes of Dr. Danielyan's work for reviewing the information and answering the questions.
- You have asked all the questions you had about the doctor's email policies and your questions were answered to your satisfaction. You understand the policies and agree to abide by them in full.

Agreement

I have read and understand the information above, and had any questions answered to my satisfaction. I agree to the guidelines for e-mail communication.

Patient's name: _____ Date: _____

Patient's/Parent's/Legal guardian's signature: _____

Patient's/Legal guardian's email address: _____

Provider's Email address:info@baypsychiatry.com

Arman Danielyan, M.D.

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Telepsychiatry Consent Form

I hereby authorize Dr. Arman Danielyan to use telepsychiatry for diagnostic and treatment purposes for me or my child. I understand the risks of using telepsychiatry for my/my child's treatment. I understand that using telepsychiatry involves the communication of my medical information, both orally and/or visually, to physicians and other health care practitioners located in other parts of the State.

I understand I have all the following rights with respect to telepsychiatry:

- I have the right to withhold and/or withdraw my consent to use telepsychiatry at any time during the course of treatment. Withdrawing or withholding my consent will not affect the availability or quality of care I would have received otherwise.
- The confidentiality of protected health information (PHI) laws applies to telepsychiatry as well. I understand that my telepsychiatry sessions will not be video or audio recorded. My PHI will be kept secure and confidential. I also understand that there are both mandatory and permissive exceptions to confidentiality, as mandated by the California State laws, including, but not limited to reporting child and elder abuse; expressed threats of violence towards an identifiable victim etc.
- I have the right to request copies of my medical records, including the psychiatric evaluation and progress notes reflecting the content of the telepsychiatry sessions. I may obtain copies of my medical records for a reasonable fee.
- I understand that there are risks associated with telepsychiatry service including, but not limited to, the possibility of the transmission of the medical information being disrupted or distorted by technical failures; the transmission of my medical information being interrupted by unauthorized persons; and/or the electronic storage of my medical information being accessed by unauthorized persons.
- I understand that professional service and care provided via telepsychiatry may not be as complete as face-to-face services. I also understand that Dr. Danielyan may recommend to discontinue telepsychiatry and to engage in face-to-face services. I understand that I may benefit from telepsychiatry, but that there may also be worsening of my condition as a result of telepsychiatry treatment.
- I understand that there might be other risks associated with telepsychiatry service that are not listed here, and that I consent to engage in telepsychiatry service provided by Dr. Danielyan.

I have read and understand the information provided above, I have discussed it with my physician or my physician's staff, and all my questions have been answered to my satisfaction

_____	_____	_____
Patient's/Parent's/Legal Guardian's name	Signature	Date

_____	_____
Treatment provider signature	Date

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Consent to Use AI Scribe during Medical Encounters

Dear Patient/Guardian,

I would like to inform you about a new technology that I am using called Nabla Copilot. Nabla Copilot is an artificial intelligence (AI) tool that assists us during patient encounters by generating clinical notes based on our conversations. This tool allows us to focus more on you, the patient, and less on computer documentation. Nabla Copilot is a tool that listens to the conversation during a medical consultation and generates a written summary or "note" based on that conversation. This note is then reviewed and approved by your doctor.

How will this affect you?

Nabla Copilot tool does not interact with you directly. It merely listens to the conversation and creates a summary. This can allow the doctor to focus more on the visit and less on taking notes.

Data Privacy and Confidentiality

I would like to assure you that your privacy is my utmost priority. The Nabla Copilot adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes.

Your Consent

Your participation is completely voluntary. If you agree to the use of Nabla Copilot during your consultations, please sign and date the form below. If you have any questions or concerns, please feel free to discuss them with us.

I, _____, consent to the use of Nabla Copilot during my medical/psychiatric encounters/appointments.

Signature: _____ Date: _____

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Release of Information

I, _____, hereby authorize Arman Danielyan, MD, to have bilateral exchange of information that is contained in my medical records with:

Name:_____; Organization: _____

Address: _____

Tel/Fax: _____; Email: _____

under the conditions listed below:

1. This information will be limited to:
   ____Psychiatric/medical/alcohol/drug abuse evaluation.
   ____Psychiatric/medical/alcohol/drug abuse discharge summary.
   ____ Progress notes. ____Psychological testing.
   ____ Lab studies. ____ Medical tests/studies.
   ____ Other _____

2. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon 90 days

3. Additional consent must be obtained for any other transfer or disclosure of this information. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

4. I understand that I may receive a copy of this release.

This authorization is valid for 90 days from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel.

_____ _____

Patients Name Date of Birth

_____ _____

Signature Date

_____ _____

Guardian's Signature (if patient is a minor) Date

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Office Policies and Procedures.

I. Confidentiality:

Please review the copy of privacy practices before signing this document. I maintain a record of your treatment. You have certain rights with regard to accessing your records. Please direct your inquiries about access to your records to Dr. Arman Danielyan.

Communications between the patient/parents/guardians are confidential. No information will be released to the third party without your consent, except for the following situations:

- Consultation with other current health care providers, if pertinent to treatment.
- Instances where the patient may be an imminent threat to self or others, unable to take care of basic needs, or in cases of suspected child or elder abuse.
- When ordered by a court.
- Some treatment information such as name, diagnosis, date of service and charge is routinely given to your insurance company to facilitate reimbursement.
- Some companies request additional information for treatment authorization

II. Appointments and Cancellations:

All sessions are arranged by appointment only. Please be on time for your appointment. Sessions cannot be extended if you arrive late. Your appointment will be cancelled if you arrive more than 20 minutes late, and you will be responsible for the payment of full session fee. Monday appointments require notification before 5:00 p.m. the preceding Friday. Cancellation of your appointment on any other day of the week should be made at least 48 hours in advance. You will be charged $400 for cancelled or missed initial appointment and $200 for missed follow-up appointment unless I receive adequate notification. Please be aware that insurance companies will not reimburse for missed visits, making you responsible for the charged fee.

III. Fees and Payments:

- Payment for the appointment fee and any ancillary charges is due at the beginning of every session. I accept cash, credit card or personal checks only.
- I charge $600.00/hour. My initial diagnostic interviews last up to 90 minutes. I often require a second interview within 1-2 weeks for complete assessment. My follow/ up visits last either 25 or 55 min., depending on the complexity of the case.
- Although I contract with some health insurance companies, it is YOUR responsibility to confirm If I am a network provider for your particular insurance and group plans . By signing this agreement you indicate your informed willingness to personally accept financial liability for services rendered by Dr. Danielyan in case if your insurance provider refuses to reimburse Dr. Danielyan for his professional services.

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- Copayment are due at the time of service. Checks returned by the bank will be charged a $50 fee. Accounts with balances more than 30 days past due will be charged $50 late fee per month. Accounts with balances more than 3 months past due will be turned over to a collection agency and reported to credit bureaus.
- Telephone calls/appointments and report/forms preparation lasting longer than 5 minutes will be charged according to my hourly rates of $600/hour in 10 minute increments.

IV. Prescription Refill Requests

- In order to continue to prescribe a medication, I need to see you in person in order to assess for efficacy and side effects and potentially make additional adjustments.
- Anticipate any refill needs and discuss during the office visit. Calling in a refill is considered a courtesy needed when appointments are changed unexpectedly or due to recommended medication adjustments. You will be charged $50 fee for refills inbetween the appointments
- Requests for refills may take up to 72 hours and are not done on weekends or holidays.

V. ANCILLARY SERVICES

I charge for any time I spend providing care for you or your child, such as telephone calls involving clinical concerns, e-mails, medication refills, and preparation of forms, letters or reports. Generally ancillary services, such as these, will not be reimbursed by medical insurance and will be your sole responsibility

VI. TELEPHONE ACCESS

I will return your phone calls within 24 hours. Please call 911 or report to the nearby Emergency room in case of any medical or psychiatric emergency. Please do not email me in case of any medical or psychiatric emergencies.

By signing below I attest my agreement and willingness to comply with the Office Policies and Procedures. The Office Policies and Procedures are subject to change without prior notice. However, I will make every possible effort at informing you as soon as possible of any changes and updates. Thank you.

_____ _____

Patient's or Parent's/Legal Guardian's Name Date

_____

Patient's or Parent's/Legal Guardian's Signature

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Credit Card Authorization Form.

Dear Patient/Guardian,

As described in the office policies, the payments are due at the time of service. If you are unable to attend, or need to reschedule your appointment, please do so 48 hours prior to your scheduled appointment time. You will be charged the full fee if you fail to show up for your appointments and do not notify Dr. Danielyan 48 hours in advance.

Thank you for your cooperation.

Arman Danielyan, M.D.

I, the undersigned individual, authorize Arman Danielyan, M.D. to charge my credit card in the event if I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify Dr. Danielyan at least 48 business hours in advance for a cancelled appointment, as agreed to in the "Office Policies and Procedures". I also authorize Dr. Arman Danielyan to charge my credit card for the full amount due for outstanding payments of services rendered. I agree to not dispute charges for any of these reasons. I further authorize Dr. Arman Danielyan to disclose information about my attendance and/or cancellation to my credit card company if I dispute a charge.

This form will be securely stored in your clinical file and may be updated upon request at any time.

Credit Card Type: ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Credit Card #: _____; Expiration Date:_____; Verification code: _____
Name (as printed on card): _____
Billing Address: _____
Street City State Zip

Signature: _____ Date: _____
Patient or financially responsible party

*Please note: your credit card will not be charged unless one of the following conditions apply:

- no-show for a scheduled appointment,
- cancellation less than 48 business hours in advance, or
- participation in treatment (e.g., appointment or phone session) without payment rendered.

PLEASE SIGN AND DATE BELOW IF YOU WOULD LIKE Arman Danielyan, M.D. TO BILL THE ABOVE CREDIT CARD FOR REGULARLY SCHEDULED APPOINTMENTS:

Signature: _____ Date: _____
(Patient or financially responsible party)

*Office use only: Obtained copy of credit card (front & back)

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.

2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.

3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.

2. Consider work/school, social and family settings.

3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

The Value of Screening for Adults With ADHD

Research suggests that the symptoms of ADHD can persist into adulthood, having a significant impact on the relationships, careers, and even the personal safety of your patients who may suffer from it.[1-4] Because this disorder is often misunderstood, many people who have it do not receive appropriate treatment and, as a result, may never reach their full potential. Part of the problem is that it can be difficult to diagnose, particularly in adults.

The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organization (WHO), and the Workgroup on Adult ADHD that included the following team of psychiatrists and researchers:

- **Lenard Adler, MD**
  Associate Professor of Psychiatry and Neurology
  New York University Medical School

- **Ronald C. Kessler, PhD**
  Professor, Department of Health Care Policy
  Harvard Medical School

- **Thomas Spencer, MD**
  Associate Professor of Psychiatry
  Harvard Medical School

As a healthcare professional, you can use the ASRS v1.1 as a tool to help screen for ADHD in adult patients. Insights gained through this screening may suggest the need for a more in-depth clinician interview. The questions in the ASRS v1.1 are consistent with DSM-IV criteria and address the manifestations of ADHD symptoms in adults. Content of the questionnaire also reflects the importance that DSM-IV places on symptoms, impairments, and history for a correct diagnosis.[4]

The checklist takes about 5 minutes to complete and can provide information that is critical to supplement the diagnostic process.

References:
1. Schweitzer JB, et al. Med Clin North Am. 2001;85(3):10-11, 757-777.
2. Barkley RA. Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment. 2nd ed. 1998.
3. Biederman J, et al. Am J Psychiatry.1993;150:1792-1798.
4. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association. 2000: 85-93.

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.[1]

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or **"Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke's Medical Center.

[1] Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire." *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems 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 _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005