David Kan, M.D.
ADDICTION, FORENSIC & GENERAL PSYCHIATRY

2960 Camino Diablo
Walnut Creek, CA 94597
Tel: (925) 953-2833
Fax: (925) 407-2783
www.davidkanmd.com

Dear Prospective Patient,

I would like to extend a sincere thank you for considering working with me. This new patient package asks for a lot of information. I request all of this information for the following purpose – I want to provide you the best care possible.

A patient-physician relationship works best when both parties work with as much information as possible.

I want to know your health history. Many conditions can affect your mental health. These conditions can include the effects of medical illness, both diagnosed and undiagnosed. You may not need to see a psychiatrist.

I believe it is critical to collaborate with your other healthcare providers. Recovery from medical and mental illness is a team sport. We all do better together than separately. Collaborating with your treatment providers allows for collaborative solutions and reduces the risk of medical errors such as mixing medications that shouldn't be mixed.

I believe it is important for you to understand how my practice works. Healthcare procedures and pricing are often confusing. I believe that you should know what to anticipate when you come into my practice.

Most importantly, I will be fully invested in your care. You are probably suffering in some way if you are reading this. I want to help relieve your suffering. Your total health is my greatest concern.

Sincerely,
David Kan, M.D.

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WELCOME TO DR. KAN'S PRACTICE

Patient Name:_____ Date of Birth _____

Street Address: _____ City:_____ State: _____ Zip Code: _____

E-mail Address: _____

Cell Phone: Home Phone: Work Phone:

Okay to leave confidential messages at:
Home Phone Y / N Cell Phone Y / N Work Phone Y / N Email Y/ N

Emergency Contact – Name:_____ Number:_____

Preferred Pharmacy: _____
Name Address Number

I understand that I am responsible for all charges including any added costs incurred due to any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent information to insurance carriers.

I hereby accept Dr. Kan's 48-hour cancellation policy. This policy applies to business hours as messages are not checked on weekends or holidays. I understand that my credit card will be billed on the next business day after my missed appointment, unless I have made prior arrangements with my doctor.

Signature of Responsible Party: _____ Date: _____

PATIENT ACKNOWLEDGMENT OF CONSENT FOR TREATMENT: I hereby acknowledge that I have received and reviewed a copy of Dr. Kan's consent for treatment form.

Signature of Patient: _____ Date: _____

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received and reviewed a copy of the Privacy Notice.

Signature of Patient: _____ Date: _____

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CREDIT CARD AUTHORIZATION

Patient Name _____

Dr. Kan keeps credit cards on file for all patients. This information is stored securely in your electronic chart. Your credit card will be billed for all charges on the next business day, unless the account is paid by check or cash.

This form is to be completed by patient or guardian.

I, _____, hereby authorize David Kan, M.D. to charge my credit card to pay for my sessions and any other charges I incur for psychiatric treatment. I affirm that I am at least 18 years old and that I am legally authorized to use the credit card account number specified below. I understand that I will be charged for the full amount. I will not dispute sessions that I have received or that I have not cancelled less the 48 hours in advance.

I authorize Dr. Kan to accept updated account information verbally.

If the information below changes, I will let Dr. Kan know immediately.

Card Type (circle one): Visa / Mastercard / American Express / Discover

Account Number _____

Expiration: _____/_____

Security Code (3 or 4 digits) _____

Name (as it appears on the card):

_____

Credit Card Billing Address:

_____

_____

_____ _____

Signature of Card Holder Date

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CONSENT FOR TREATMENT

Welcome to our practice. This information sheet covers a number of important issues related to your treatment. Please read it and acknowledge receipt by signing the intake form.

CONFIDENTIALITY

Our practice safely stores your protected health information. Our electronic charting and email system are securely encrypted to maintain your confidentiality.

Our providers must have your permission before revealing any information about you, with the following exceptions:

1. **Legal limitations** – We are obligated by law to disclose information under certain legally defined situations; (1) if you are an imminent danger to yourself or others; (2) if you tell us about an incident of child abuse by you or someone else; (3) if you tell us about an incident of abuse of someone over age 65 or a disabled adult; (4) if you are unable to provide food, clothing or shelter for yourself; (5) if the court orders a release of information.
2. **Insurance companies** – If Dr. Kan is contracted with your insurance panel or you submit invoices to your insurance company, be aware that the company may request certain information from us as a requirement of your reimbursement. This information could include dates of appointments, diagnoses, medications prescribed, and treatment summaries.
3. **Communications with others** – In order to provide you with excellent medical care, we may ask for consent to talk with your primary care provider. We keep an emergency contact on record to be used only in the case of an emergency.

PROVIDER AVAILABILITY

1. **Phone calls** – Our staff is available during work hours to answer your calls and emails to help with scheduling or billing questions. If you prefer more privacy, you may leave a message on your Dr. Kan's voicemail or email that will be returned as soon as possible.

   We do not charge for phone calls lasting less than five minutes. Longer calls are prorated.

   Please keep in mind that insurance companies do not cover phone calls and patients are responsible for those charges. In order to provide you with excellent care, your physician may make collateral phone calls to your other providers.

2. **After hours phone calls** – Our providers can be reached after hours through our voicemail system. If you are having a clinically urgent situation on an evening, weekend or holiday, you can contact Dr. Kan. If you are having a medical or psychiatric emergency, do not wait for a call back but instead call 911 or go to your

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nearest emergency room.

3. **Email** – My practice is maintains patient confidentiality and I encrypt your protected health information. When you receive an encrypted email from Dr. Kan, you will be asked to create a password and sign in. Please keep in mind that emails you send through your server may not be secure.

4. **Texting** – Texting is not a secure form of communication. Our providers do not return text messages but instead will respond by secure email.

5. **Refill requests** – Please allow two days for refill orders to be sent in. We are not allowed to authorize refills if you do not have a future appointment scheduled.

SCHEDULING

1. **Length of sessions** – Intake consultations are 60 minutes, psychotherapy sessions are 45 minutes, and medication management appointments are 25 minutes. Our providers start and end sessions on time.
2. **Appointment reminders** – Our office sends email and phone message reminders three days prior to your scheduled appointment. If you receive an appointment reminder in error, please call or email the office to clarify or cancel.
3. **Missed appointments** – We ask for a 48-hour notice for any cancellations. This policy is for business hours. For example, if your appointment is on a Monday we request notice by Thursday. *Be aware that insurance companies do not cover missed sessions and you will be charged the full cash fee for the appointment.*
4. **Holidays and vacations** – Dr. Kan observes holidays and our clinicians take about three weeks of vacation each year.

BILLING

1. **Payment** – Payment is collected at the time of service by cash, credit card, or check made out to David Kan, M.D. For your convenience, we keep a current credit card on file for all patients. This information will be stored securely in your chart.
2. **Insurance billing** – Dr. Kan is an out-of-network provider with all insurance companies. Payment in full is required at each appointment. Our office is happy to assist you with getting reimbursement from your insurer for any out-of-network benefits you have. If your insurer allows electronic claims, our office will submit the claim on your behalf. If your insurer does not allow electronic claims for patient reimbursement, then we will provide you with the documentation you need to submit the claim yourself.
3. **Medicare** – For administrative and legal reasons, we have opted out of Medicare. If you are eligible for Medicare, please sign an agreement with Dr. Kan stating that you will not submit invoices to Medicare.
4. **Statements** – If you are paying out of pocket for your visits, statements are mailed upon request. You are welcome to request documentation of payment at any time.

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2015 FEE SCHEDULE

- General Adult Psychiatry Fees – For adults 20 years old and up
- Initial assessment, 60 minutes, $425
- Buprenorphine/Suboxone Induction, 90-120+ minutes, $800
- Individual psychotherapy, 45 minutes, $275
- Couples or Family therapy, 45 minutes, $275
- Medication Management appointment, 25 minutes, $225
- Extended (over 5 minutes) phone contact, $5 per minute
- Document preparation for a third party, Varies (attorney, employer, etc.)
- Medical records handling/copying, $30 plus $1.15 per page for first 30 pages, $0.90/page thereafter
- Fee for NSF (bounced) check, $35
- Between-visit prescription refill, $25
- Urgent prescription refill, $35
- Appointment Missed, or Canceled, Full Appointment Fee without 48 hours notice

Fees are increased by approximately 3% a year starting on January 1st.
Please keep a copy of this for your records and sign the intake form to acknowledge receipt of this consent.

I look forward to working with you.

_____ _____
Patient Signature Date

_____
Patient Name Printed

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History Questionnaire

Please fill out the following questionnaire as completely as possible. However, if you are uncomfortable answering any question, you may simply skip it.

What is the name and phone number of your primary care doctor? _____

What is your current relationship status? ***(Please check one)***		
☐ Never married	☐ Divorced	☐ Married
☐ Widowed	☐ Separated	☐ Committed relationship
☐ Other (describe: _____)		

What is your ethnic background? ***(Please check all that apply)***		
☐ African American	☐ Caucasian	☐ Native American
☐ Asian/Pacific Islander	☐ Hispanic/Latino	☐ Other (describe: _____)

Whose ideas was it that you come to the care? ***(Please check all that apply)***	
☐ My own idea	☐ My doctor's idea
☐ Family, friend or spouse's idea	☐ Other _____

Of the below, what concerns would you like to discuss in your visit today? ***(Please check all that apply)***

☐ 1. Depressed, sad mood	☐ 19. Learning problems
☐ 2. Suicidal thoughts	☐ 20. Memory problems
☐ 3. Low energy, tiredness	☐ 21. Concentration or attention problems
☐ 4. Poor sleep	☐ 22. Hyperactivity
☐ 5. Self-harm behaviors (i.e., cutting or burning self)	☐ 23. Racing thoughts
☐ 6. Loss of interest or loss of pleasure in life	☐ 24. Mood swings
☐ 7. Panic or anxiety attacks	☐ 25. Jealousy
☐ 8. Excessive worrying	☐ 26. Paranoia
☐ 9. Phobias (excessive fear) of certain things	☐ 27. Physical problems
☐ 10. Alcohol use	☐ 28. Pain
☐ 11. Drug use	☐ 29. Sexual preoccupations
☐ 12. Trauma	☐ 30. Thoughts of harming someone
☐ 13. Disturbing nightmares or memories	☐ 31. Self-esteem problems
☐ 14. Irritability/frequent anger	☐ 32. Sexual performance problems
☐ 15. Obsessions (Unwanted thoughts you can't stop)	☐ 34. Hearing voices or having visions
☐ 16. Unwanted behaviors you can't stop	☐ 35. Gambling, excessive spending, multiple sexual partners
☐ 17. Grief	☐ 36. Other – ***please specify***
☐ 18. Eating disorder (i.e., throwing-up after eating, excessive dieting, excessive eating)	

Of the problems listed above, what are your top 3 current concerns? (***Enter their numbers on the lines below***):

Top-most concern: _____ Second-most concern: _____ Third-most concern _____

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Review of Systems

Are you currently having, or have you had problems with: (check all that apply)

General well-being
__ Fever
__ Weight loss (>10#)
__ Excess fatigue
__ Recurrent Nausea / vomit
__ Night sweats

Eyes
__ Wear glasses
Date of last exam _____
__ Infections
__ Injuries
__ Glaucoma
__ Cataracts
__ Blurred vision
__ Trouble focusing
__ Recent change in vision

Ears, Nose, Mouth and Throat
__ Wear hearing aids
Date of last exam_____
__ Hearing loss
__ Ear infection
__ Pressure in ears
__ Ringing in ears
__ Pain in ears
__ Balance disturbance
__ Itching in ears
__ Dizziness
__ Nasal congestion
__ Nasal drainage
__ Nosebleeds
__ Sinus problems
__ Sinus infections
__ Sinus headaches
__ Throat infections
__ Difficulty swallowing
__ Lip or mouth sores
__ Sore throats

Respiratory
__ Chronic cough
__ Emphysema
__ Bronchitis
__ Asthma
__ Chronic obstruction
__ Pulmonary disease
__ Shortness of breath
__ Oxygen use at home
__ Pneumonia
__ Lung cancer
__ Tuberculosis
__ Blood in saliva
Date of last chest X-ray_____

Cardiovascular
__ Chest pain
Date of last EKG _____
__ Heart attack
__ High blood pressure
__ Low blood pressure
__ Irregular heartbeat
__ Heart murmur
__ Arm and leg swelling
__ High cholesterol

Gastrointestinal
__ Blood in vomit
__ Indigestion
__ Nausea / vomiting
__ Jaundice
__ Abdominal pain
__ Change in bowel habits
__ Ulcers or Gastritis
__ Colon, liver, stomach cancer
__ Hepatitis

Hematologic
__ Anemia
__ Hemophilia
__ Easy bleeding / bruising __ Swollen glands

Genitourinary
__ Urinary tract infection
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Kidney stones
__ Prostate cancer
__ Endometriosis
__ Uterine, ovarian or cervical cancer

Neurological
__ Disorientation
__ Fainting / blacking out
__ Light headedness
__ Seizures
__ Stroke
__ Mini-stroke
__ Memory problems
__ Concentration problems
__ Speech problems
__ Facial weakness/ spasms
__ Muscle weakness
__ Coordination problems
__ Uncontrolled shaking
__ Headache
__ Migraine

Endocrine
__ Diabetes
__ Hormone problems
__ Low blood sugar
__ Thyroid disease
__ Increased appetite
__ Excessive thirst
__ Excessive urination
__ Temperature intolerance
__ Pituitary gland problems
__ Bleeding tendencies

Immunologic
__ Environmental allergies
__ Hay fever
__ Food allergies
__ Immune system problems
__ Connective tissue disease
__ Frequent colds / infections

Skin
__ Eczema or psoriasis
__ Dermatitis
__ Dry or scaling skin
__ Rashes
__ Changes in skin color
__ Changes in moles
__ Skin cancer
__ Breast pain or swelling
Date of last Mammogram
_____

Musculoskeletal
__ Broken bones
list:_____
__ Arm or leg weakness
__ Joint pain or swelling
__ Back pain
__ Arthritis

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Are you currently taking any medications for a mental health disorder or illness? ☐ **Yes** ☐ **No**
If yes, please list the medication(s) and dosage:

_____

_____

Have you previously taken any other medications for your mental health? ☐ **Yes** ☐ **No**
If yes, please list the medication name(s), when you took the medication, and the dosage:

_____

_____

Have you ever needed care in a mental health hospital? ☐ **Yes** ☐ **No**
If yes, where and when were you hospitalized?

_____

Are you currently seeing a mental health provider?..... ☐ **Yes** ☐ **No**
If yes, please list their name(s) and contact information:

_____

Do you have any medical problems? ..... ☐ **Yes** ☐ **No**
If yes, please list them here:

_____

_____

Are you taking other medications, other than mental health medications already listed above? ☐ **Yes** ☐ **No**
If yes, please list them here:

_____

_____

Are you allergic to any medications or have other allergies? ☐ **Yes** ☐ **No**
If yes, please describe what you are allergic to and the allergic response that you have:

_____

Have you ever had a head injury or traumatic brain injury? ☐ **Yes** ☐ **No**
(Sometimes referred to as a "concussion" or "having your bell rung.")

If yes, did it involve loss of consciousness or "seeing stars" at the time of the injury? ☐ **Yes** ☐ **No**
Are you having any pain at this time? ..... ☐ **Yes** ☐ **No**
If yes, are you currently being treated for your pain? ... ☐ **Yes** ☐ **No**
If yes, on a scale of 0-10 (no pain to terrible pain), how severe is the pain? _____
If yes, where is the pain located? (List all locations)

_____

Nutrition:

I have concerns about my eating habits: ☐ Yes ☐ No ***(Please check all that apply)***	
☐ I have gained more than 10 pounds in the last 6 months without trying	☐ My meals are not well-balanced (lots of fast food; lots of junk food; not many fruits and vegetables)
☐ I have lost more than 10 pounds in the last 6 months without trying	☐ Other (***please specify***):

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Substance Use:

How often did you have a drink containing alcohol in the past year?				
Never	Monthly	2-4 times a month	2-3 times a week	4+ times a week

How many drinks containing alcohol did you have on a typical day when you are drinking in the past year?					
0	1 or 2	3 or 4	5 or 6	7 or 9	10 or more

How often did you have six or more drinks on one occasion in the past year?				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Do you smoke cigarettes or use any other form of tobacco?	**Yes** ☐	**No** ☐
If **Yes**, how many cigarettes per day?	_____ cigarette(s) per day	
If **Yes**, Would you like help quitting?	**Yes** ☐	**No** ☐
How many caffeinated drinks per day do you consume (e.g., coffee, black tea, soda, energy drinks)?	_____ drink(s) per day	

For the following substances, please indicate **age of first use**, **date of last use**, and **number of days you have used the substance in the past 30 days** (if any). Just APPROXIMATE if you are unsure.

	Age of 1st Use (write X if never used)	**Date** of Last Use (Skip if never used)	Days used in the **past 30 days** (skip if not used in the past 30 days)
Alcohol			Days
Cocaine/crack			Days
(Meth)amphetamine (E.g. speed, "crystal meth," "ice")			Days
Non-Prescribed use of amphetamines (e.g. Dexadrine, Ritalin, Adderall)			Days
Non-Prescribed use of opiates (e.g., heroin, vicodin, oxycontin, percocet)			Days
Non-Prescribed use of sedatives/tranquilizers (E.g., "benzos", Valium, Xanax, Ativan, Klonopin, Ambien, other sleep medications)			Days
Marijuana (cannabis, pot, hash, weed)?			Days
Tobacco/Nicotine			Days
Hallucinogens (e.g. LSD, ecstasy)			Days
Other drugs (inhalants, steroids, other over-the-counter/unknown medications, or anything ordered over the internet, etc.)			Days

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Family history:

Do any of your family members have a psychiatric or neurological disorder or illness? ☐ **Yes** ☐ **No**

If yes, please describe:

_____

Social History:

Who raised you? ***(Please check all that apply)***	
☐ Biological mother	☐ Step-father(s)
☐ Biological father	☐ Non-relatives, including foster and adoptive parents
☐ Step-mother(s)	☐ Foster care or other setting

As a child, were you ever mistreated? ***(Please check all that apply)***			
☐ Physically	☐ Emotionally/verbally	☐ Sexually	☐ Not abused

As a child, …		
☐ I was arrested before the age of 18 for ***(Please check all that apply)***:		
☐ running away	☐ delinquency	☐ curfew violation
☐ truancy	☐ theft	☐ other (what? _____)
☐ burglary	☐ alcohol/drug possession	☐ not applicable

How many times have you been married (***indicate number***)? _____		
With whom do you live now? ***(Please check one)***		
☐ Alone	☐ Family	☐ Retirement Center
☐ Spouse	☐ Friend	☐ Homeless
☐ Significant Other	☐ Group Home	☐ Other (describe: _____)

Are you in a relationship with someone now (married, living with someone, or some type of committed relationship)?	☐ Yes	☐ No	
If yes, how is your relationship with your significant other?	☐ Good	☐ Fair	☐ Poor
How many children do you have?	Sons -	Daughters -	
If yes, how is your relationship with your children?	☐ Good	☐ Fair	☐ Poor

Have you ever been a victim of domestic violence? ..... ☐ **Yes** ☐ **No**

If yes, please let us know the circumstances:

_____

Have you ever been involved in a physical altercation? ☐ **Yes** ☐ **No**

If yes, please let us know the circumstances:

_____

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Educational History:

How far did you go in school?	
☐ Grade 11 or lower	☐ Associates' degree (AA)
☐ GED	☐ Bachelors' degree (BA, BS)
☐ High school graduate	☐ Masters' degree
☐ Some college	☐ Other: _____

Military History:

Period of service: Induction date: _____ Discharge date: _____

Highest rank attained: _____ Military Occupational Specialty: _____

What branch of military service? *(Please check **all** that apply)* ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ National Guard ☐ Navy ☐ Other (please specify): _____

Were you in a combat zone? ☐ Yes ☐ No

If yes, in which combat zone did you serve? ☐ WWII ☐ Korea ☐ Vietnam ☐ Persian Gulf ☐ OIF/OEF ☐ Other (please indicate): _____

Work history:

Are you ...	**Yes**
1. Employed full-time	☐
2. Employed part-time	☐
3. Unemployed, and looking for work	☐
4. Unemployed, and not looking for work	☐
5. A full-time student	☐
6. A part-time student	☐
7. Disabled	☐
8. Retired	☐
What is your current monthly income?	$_____
If you are not currently working for any reason, when did you last work (please specify year)?	

Do you have income from… *(Please check all that apply)*	
☐ Employment	☐ Social security retirement
☐ Service-connected disabilities	☐ Social security disability
☐ Non-service connected disabilities	☐ Employment pension plan

Cultural/Spirituality:

Does religion/spirituality play an important role in your life? ☐ Yes ☐ No

Are there aspects of your religion/spirituality that may be significant in your treatment? ☐ Yes ☐ No

If yes, please explain:

_____

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Please share any aspects of your culture/ethnic background that may be significant in your treatment:

_____

Leisure Activities/Hobbies/Exercise:
Do you participate in any leisure activities, hobbies, or exercise? ☐ Yes ☐ No

If yes, what activities?

_____

Legal Issues:

	Yes	No
Have you ever been convicted of, or pleaded guilty or no contest to a misdemeanor or felony, other than a minor traffic violation, or is there any such charge now pending?	☐	☐
If yes, what was the charge(s) (***please list***):		
Are you on parole or probation (to include deferred adjudication or pre-trial diversion)?	☐	☐
Do you have any criminal charges currently pending?	☐	☐
Are you now the subject of a criminal investigation by any law enforcement agency?	☐	☐
Has your driver's license ever been suspended or revoked?	☐	☐

Over the last TWO WEEKS, how often have you been bothered by any of the following problems?
Please circle your response.

	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 fidgety 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 in some way?	0	1	2	3

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If you checked off any problems above**, 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?**

0	1	2	3
Not Difficult at all	Somewhat	Very difficult	Extremely difficult

Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you…		
Had nightmares about it or thought about it when you did not want to?	**Yes** ☐	**No** ☐
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	**Yes** ☐	**No** ☐
Were constantly on guard, watchful, or easily startled?	**Yes** ☐	**No** ☐
Felt numb or detached from others, activities, or your surroundings?	**Yes** ☐	**No** ☐

Other Stressful Life Experiences:

Please NOTE: Some people become upset when reading the questions below. Only read them if you feel safe to do so, and stop if they are too upsetting.

Have you ever been in a major natural disaster or accident that resulted in significant loss of property or serious injury/threat to yourself or someone close to you?	**Yes** ☐		**No** ☐
If yes, how upsetting is the experience now?	**Not at all** ☐	**Somewhat** ☐	**Very** ☐
Have you ever received unwanted sexual attention (i.e. touching, pressure for sexual favors, repeated sexual verbal remarks)?	**Yes** ☐		**No** ☐
…how upsetting is the experience now?	**Not at all** ☐	**Somewhat** ☐	**Very** ☐
Has anyone ever used force or the threat of force to have sex with you?	**Yes** ☐		**No** ☐
how upsetting is the experience now?	**Not at all** ☐	**Somewhat** ☐	**Very** ☐
Are you currently bothered by any other very stressful past experience that was not captured by the questions above?	**Yes** ☐		**No** ☐
If yes, how upsetting is the experience now?		**Somewhat** ☐	**Very** ☐

Anything we forgot to ask? *If there is anything we did not ask that you would like for us to know, please jot it down below:*