Stephen V. Sobel, M.D., Inc.

Diplomate, American Board of Psychiatry & Neurology
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PATIENT INFORMATION FORM

Please Print Date:

PATIENT: This section for patient only

Name _____ Sex ___ Age ____ Spouse's Name _____

Address _____ DOB ___/___/___

City _____ State _____ Zip _____Driver's License # _____

Employer _____ Marital Status M S D Sep W (Circle One)

Address _____ Cell Phone # _____

City _____ State ____ Zip _____ Work Phone # _____

Email address _____

Nearest Relative or Friend not living with you _____ Relationship _____

Address _____ Phone # _____

How did you hear about this practice? _____

RESPONSIBLE PARTY FOR BILL (If other than patient)

Name _____ Relationship to Patient _____

Address _____ Employer _____

City _____ State ____ Zip _____ Address _____

SS# _____ DOB ___/___/___ City _____State ___Zip _____

Home Phone # _____ Work Phone # _____

INSURANCE INFORMATION

PRIMARY Insurance Carrier:
Company _____

Address _____Ph_____

City _____ State ____ Zip _____

INSURED _____ DOB _____

(Name on Insurance Card)

Patient's relationship to Insured:

Self ( ) Spouse ( ) Child ( ) Other ( )

INSURED ID # _____

Group or Plan # _____

Effective Date of Insurance _____

Date of Injury/Crime _____

SECONDARY Insurance Carrier:
Company _____

Address _____Ph_____

City _____ State ___ Zip ___

INSURED _____ DOB _____

(Name on Insurance Card)

Patient's relationship to Insured:

Self ( ) Spouse ( ) Child ( ) Other ( )

INSURED ID # _____

Group or Plan # _____

Effective Date of Insurance _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment direct to Stephen V. Sobel, M.D. of the Insurance Benefits otherwise payable to me and authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance and/or missed appointments or cancellations with less than 24 hours notice. A copy of this signature is as valid as the original.

_____ **Date** _____

Responsible Party

OFFICE POLICIES/TREATMENT AUTHORIZATION

WHO IS STEPHEN SOBEL, M.D.?

I am a Board Certified Psychiatrist and a Diplomate of the American Board of Psychiatry and Neurology. I was raised in Miami, Florida. I graduated with honors from Duke University and Vanderbilt University Medical School and completed an Internship in Internal Medicine with Georgetown University prior to moving to San Diego where I completed a Residency in Psychiatry at UCSD. I have special interests in the treatment of Depression, Anxiety Disorders, Mania, Self-esteem Issues, Eating Disorders, ADD, and work-related stress. I utilize short-term cognitive and dynamic psychotherapeutic techniques plus medication when indicated. I am Consulting Psychiatrist for the NFL San Diego Chargers and the MLB San Diego Padres. I am a Clinical Instructor in Psychiatry at UCSD School of Medicine and Supervising Psychiatrist for the UCSD Free Medical Clinic for the Homeless. I was Director of the Eating Disorders Treatment Program and served a term as Chief of the Medical Staff at Charter/Alvarado Parkway Institute. I am asked to teach across the United States and internationally and have lectured to over 20,000 physicians and therapists regarding the treatment of Depression, Anxiety, ADD, Bipolar Disorder, Eating Disorders, Psychopharmacology, and Behavioral Medicine. I am the author of "Successful Psychopharmacology: Evidence-Based Treatment Solutions for Achieving Remission – A Guide for Physicians, Mental Health Professionals, and Their Patients," published by W. W. Norton and Company. I enjoy a variety of sports, especially bike riding, running, and tennis, travel, going to the movies and the theatre and playing with my wife and daughter during my time away from the office.

CONFIDENTIALITY

All communication between us is both privileged and confidential except there are certain situations in which I will release information. These include: If you consent for me to do so; if you become a danger to yourself or others; if I am ordered by a court to do so; or if a child or senior adult abuse/neglect is known or suspected. In some situations, California Law requires me to inform potential victims or legal authorities so that protective measures can be taken. There are also some situations, e.g., workers' compensation or other medical-legal evaluations or treatment in which confidentiality does not apply. If you have any questions and/or concerns regarding confidentiality or any other matter, they can be discussed during your first session. Please do not hesitate to bring them up.

FEES/INSURANCE COVERAGE

It is important to me that my patients understand my fees and possible methods of payment. My fees are consistent with usual and customary psychiatric fees. I belong to many managed care panels. I wish to stress that the financial responsibility for services rendered rests with the patient or the patient's family, regardless of any insurance coverage. We will provide the courtesy service of billing your insurance company for you. I ask that your estimated share be paid now. This is the copay and deductible set by your insurance company. If any payment is subsequently paid by your insurance carrier in excess of the balance estimated, I shall promptly refund or credit you this amount. I reserve the right to charge a processing fee of $35 per month for all copays and deductibles not paid at the time of service. Please sign here stating that you understand and agree to abide by this.

I prefer to pay at this time _____

I cannot pay at this time. _____

My fee for an initial consultation is $280. Standard fees are $240 for a full psychotherapy session and $140 for a medication management session.

My billing secretary needs a claim form that has been completely filled out by you to process your insurance, plus a copy of the front and back of your insurance card. You are responsible to know the limitations of your policy and notify us of these. Until we know the limits of your insurance, it will be necessary for you to pay at time of service. If you need any assistance, I will try to help you with this. Please feel free to discuss this with me at our first session. Payment is expected at the time of service unless you have made other arrangements. Interest charges of 1.5% per month will be added to balances of greater than thirty (30) days.

If insurance payment is delayed, you will be asked to bring your account up to date by payment in full. Any account that is outstanding may be assigned for collections. I hate doing this. You will be held responsible for the total costs involved including fees charged by a collection agency, attorney's fees and cost to process servicing. I recognize that financial difficulties do arise and I want to work these out with you. Please bring these up during your first sessions so we can discuss them and they can be resolved in a mutually satisfactory way. I am happy to work on a sliding scale basis when financial need exists.

I authorize Stephen V. Sobel, M.D., Inc. to charge my credit card for any unpaid balances at his discretion.
Master Card ( ) Visa ( ) Name on Card _____
Credit Card No. _____ Expiration Date: _____ 3-Digit Code: _____
Signature: _____ (back of card)

APPOINTMENT CANCELLATIONS

Appointments are made on a regular, often weekly basis and your appointment time is held for you. We have a contract whereby you have the exclusive and reserved use of my time for your scheduled appointments. I make a great effort to always be punctual. You are, therefore, held responsible for all canceled appointments. In the event that you are unable to keep your appointment, you must cancel as soon as possible. Should you fail to cancel an appointment 24-hours or more in advance, you will be held responsible for full payment for that service and will be billed accordingly. We cannot bill your insurance company for these missed appointments. If you do not notify me of your need to cancel and simply do not appear for our scheduled and exclusively reserved appointment time, you will be held similarly responsible. Of course, I understand that emergencies occur which may prevent you from coming in for our appointment and giving me 24-hours notice. Please notify me of these emergencies as soon as possible. Of course, there is no charge for appointments missed in these circumstances. I would appreciate if you would leave me a brief explanation for the reason you are canceling an appointment when you call. Please note that a message regarding cancellations or ay other matter can be left with my answering service or me 24-hours a day, seven days a week.

I HAVE READ AND UNDERSTAND THE POLICY INFORMATION. I VOLUNTARILY AGREE TO THE TERMS PROVIDED AND AUTHORIZE TREATMENT IN ACCORDANCE WITH IT.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I HEREBY AUTHORIZE PAYMENT DIRECT TO STEPHEN V. SOBEL, M.D. OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME AND AUTHORIZE RELEASE OF INFORMATION NECESSARY TO PROCESS A CLAIM WITH MY INSURANCE COMPANY. I HEREBY ACCEPT RESPONSIBILITY FOR ANY CHARGES NOT COVERED BY MY INSURANCE AND/OR MISSED APPOINTMENTS FOR CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE. A COPY OF THIS SIGNATURE IS AS VALID AS THE ORIGINAL.

_____ **DATE** _____
Responsible Party

Stephen V. Sobel, M.D., Inc.

Name: _____ Date: _____

What are the problems that bring you to see me for treatment?

Have you had previous or current treatment for these problems? If yes, when, with whom, and how did (does) it help?

Have you had any other mental health treatment? If yes, when, why, and with whom?

Have you taken any medications for depression, anxiety or other mental health problems? If yes, what medication, dose, when, for how long, and for what reason?

Please see following Page

Current medications (name, dose, how often, when started, who prescribed)?

Medication allergies:

Operations (with dates):

Other hospitalizations (when, why):

Stephen V. Sobel, M.D., Inc.

Name: _____ **Date:** _____

Have you taken any medication for depression, anxiety, or other mental health problems? If yes, please describe this below in as much detail as you can. Use additional pages if necessary:

1. **Medication** Name _____
   Dose _____ Year _____ Duration _____
   Reason _____
   Benefit _____
   Side Effects _____

2. **Medication** Name _____
   Dose _____ Year _____ Duration _____
   Reason _____
   Benefit _____
   Side Effects _____

3. **Medication** Name _____
   Dose _____ Year _____ Duration _____
   Reason _____
   Benefit _____
   Side Effects _____

4. **Medication** Name _____
   Dose _____ Year _____ Duration _____
   Reason _____
   Benefit _____
   Side Effects _____

5. **Medication** Name _____
   Dose _____ Year _____ Duration _____
   Reason _____
   Benefit _____
   Side Effects _____

6. **Medication** Name _____
   Dose _____ Year _____ Duration _____
   Reason _____
   Benefit _____
   Side Effects _____

Stephen V. Sobel, M.D., Inc.

Name: _____ Date: _____

Have you had (have):

Thyroid Disease	**___**	**Glaucoma**	**___**	**HBP**	**___**
Seizure	**___**	**Diabetes**	**___**	**Head Trauma**	**___**
Heart Disease	**___**	**Cancer**	**___**	**Orthopedic Disease**	**___**
Migraines	**___**	**Eating Disorder**	**___**	**Drug Abuse**	**___**
Alcohol Abuse	**___**	**Other: _____**			

Have you had (have) recently:

Headache	**___**	**Shortness of Breath**	**___**	**Cold Temperature**	
Palpitations	**___**	**Stomach Problems**	**___**	**Intolerance**	**___**
Skipped Heartbeats	**___**	**Constipation**	**___**	**Muscle Problems**	**___**
Dizziness	**___**	**Diarrhea**	**___**	**Joint Problems**	**___**
Fainting	**___**	**Menstrual Problems**	**___**	**Back Problems**	**___**
Chest Pain	**___**	**Urination Problems**	**___**	**Sexual Problems**	**___**
	Other: _____				

Current Physician, address, phone number, date last seen and reason:

When was your last physical examination? What were the results?

Drug/alcohol use: (for each, what, how much used on average, when last used):

What mental health, thyroid or neurological diseases run in your family (blood relatives)?

Occupation:

Employer: **How long?**

Single ____ Married ____ When? ____ Divorced _____ When? ____ Widowed ___ When? ___

Spouse's Occupation:

Describe your relationship with your spouse (be very specific):

Number of children and their ages:

Who lives with you?

Hobbies/Interests:

Name: _____ Date: _____

Birthplace:

Father's Occupation:

Describe your relationship with your father (be very specific):

Mother's Occupation:

Describe your relationship with your mother (be very specific):

# of brothers: **# of sister:**

Were you the oldest, second, what?

Parents divorced? **If yes, how old were you?**

Highest education completed, when and where?

Military Service: **When?**

What branch, duty, highest and last rank?

Describe your personality growing up (be very specific):

Describe your personality now (be very specific):