ocanxietycenter

PATIENT INTAKE FORM

The Orange County Anxiety Center (OCAC) and its providers, including Curtis Hsia, Ph.D., provide outpatient care to individuals. The goal of OCAC is to provide a high level of outpatient care for individuals who are currently experiencing anxiety disorders and related disorders. We look forward to serving you.

LIMITATIONS OF SERVICE
As an outpatient facility, OCAC does not provide inpatient care, nor is it equipped to work with individuals who need the services of an inpatient facility (e.g., individuals who are currently suicidal or homicidal, are currently experiencing hallucinations and delusions, under the effects of a substance). If, during the course of treatment, an individual believes he or she needs more intensive care and supervision, the individual should first check with OCAC and his/her provider for an evaluation. If the provider is not available, the individual should go to the nearest emergency room and/or call 911.

OUT OF OFFICE THERAPY SESSION POLICY
When out of the office together with a patient, it is impossible to guarantee confidentiality. However, every effort will be made to minimize the likelihood of being seen, heard or noticed in regards to active treatment.

If, during any treatment that occurs outside of the OCAC office, any bodily injury or illness, (e.g., slip and fall) or damage to property occurs (e.g., car accident), OCAC and its providers will not be held accountable.

CANCELLATION POLICY
If the cancellation of a therapy session is necessitated, the patient will give OCAC and its providers a 24-hour notice. If this notice is not given, the full session fee (be it a single or multiple session) will be charged. The director, Curtis Hsia, can make exceptions to this policy if an emergency occurs.

PAYMENT
Payment for the session is required by the end of the session. Credit card information of each patient will be retained by OCAC, and will be charged if a session is missed. If Dr. Hsia is required to do any legal work the patient will be charged at the standard clinical hourly rate (e.g., phone calls, report writing, interacting with attorneys). Standard clinical travel fees will also be charged.

SESSION INFORMATION
Each session is designed to last 45 minutes. On occasion they may be longer or shorter, but on average they will last 45 minutes.

PARENTS AND MINORS
When working with minors, a level of confidentiality will be maintained unless the child is at risk for harm to self or others. This is to ensure the child's safety while also helping to establish a strong working relationship with the minor.

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PATIENT OBLIGATIONS

The patient agrees to complete the weekly homework given to ensure the prompt completion of treatment and to meet treatment goals. The patient also agrees to be timely, committed and open regarding all issues, including thoughts of hurting oneself and others. If patients is not able to reach the treating therapist and feels that they are likely to hurt themselves or others, they should immediately seek help, either through calling 911, going to an emergency room or through a pre-established protocol defined and agreed upon by both the therapist and patient.

By signing this, I am stating that I have read and agree with this document, the social media document, and have been given information regarding HIPPA compliance. I have additionally been given a receipt for the initial assessment. I also agree to the stipulations stated above, and authorize OCAC and its employees to charge my credit card listed below if an appointment is missed or if 24 hour notice of cancellation has not been given. The limits of confidentiality have been explained to me, and I understand them. I also state that for the original assessment I was oriented x3, not under the influence of any medication not prescribed by a physician. I also have either denied any suicidal/homicidal ideation, or have signed a suicide/homicide contract.

Credit card number

Name on credit card

Zip code CVV #

Expiration date

Patient signature Date

Name of patient (please print)

Parent signature (if patient is a minor) Date

Name of parent (please print)