REGISTRATION FORM

	Date:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:			Home phone no.: ( )
P.O. box:	City:	State:		ZIP Code:	
Cell phone no.:	( )	Alternate Phone:		( )	
Occupation:	Employer:			Work phone no.: ( )	
Who may we thank for this referral? Name:				Phone: ( )	

PAYMENT & CREDIT CARD INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			Cell phone no.:
Credit Card: ❑ VISA ❑ MasterCard		Card number:	Expires:
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

INSURANCE INFORMATION (for medication authorizations ONLY)

Please indicate primary insurance	❑ Self Pay	❑ Blue Cross	❑ Blue Shield	❑ Medicare	❑ BMW EAP
❑ P&G EAP	❑ Motion Picture Industry	❑ Anthem	❑ Aetna	❑ Other	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

FINANCIAL AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ed S. Jesalva, MD or insurance company to release any information required to process my claims. I further authorize Ed S. Jesalva, MD to use my credit card for payment of outstanding balances including appointments missed or cancelled less than 24 hours prior to visit date.

Patient/Guardian signature *Date*

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

STANDARD FEE SCHEDULE

WELCOME TO THE PRACTICE!!

Thank you, for choosing our office for your psychiatric needs. We strive to provide a warm and compassionate environment while addressing the presenting psychiatric issues with the utmost level of professionalism and sensitivity. Our staff has years of experience to help you or your loved one today.

1. **INITIAL EVALUATION:**	**$400** (60 minutes)
2. **INITIAL EVALUATION:** (extended)	**$495** (90 minutes)
3. **MEDICATION MANAGEMENT/ 1st FOLLOW UP VISIT**	**$235** (40 minutes)
4. **MEDICATION MANAGEMENT** (uncomplicated)	**$140** (20 minutes)
5. **TELEPHONE CONSULTATION** (in lieu of an office visit)	**$140** (20 minutes)
6. **COURT APPEARANCE**, **DEPOSITIONS**	**$1,500** (retainer fee for minimum of 3 Hours **paid prior to appearance**) **$500** (for each additional hour)
7. **LETTER REQUESTS** (brief)	**$ 30**
8. **LETTER OR WRITTEN REPORT REQUESTS** (detailed)	**$ 50 on up** (depending on time)
9. **INSURANCE/DISABILITY FORMS**	**$ 50 on up** (depending on time)
10. **BILLING SUMMARIES** (extra copies)	**$ 30**
11. **RETURNED CHECKS**	**$ 30**
12. **MEDICATION PRIOR AUTHORIZATIONS**	**$ 50 on up** (depending on time)

*** PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT. _____(INITIAL)**

I have read the above and agree to its terms and conditions.

_____

Patient Signature or Parent/Guardian Date

_____

Printed Name

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

OFFICE APPOINTMENTS AND CANCELLATION POLICY

Our office tries to meet the needs of all of our patients but in particular our patients in crises that need our urgent attention. To open up appointment slots for patients in crises, the following scheduling policies are implemented:

1. All patients will be scheduled during the next available appointment slot. If this is not satisfactory, special arrangements may be made through the office manager, if possible. _____ **(initial)**

2. One day prior to the appointment, the office will try to reach you directly to confirm the appointment. If we are unable to reach you, we will try your alternate contact information. Please be aware, though, that this reminder service is a **courtesy** to our patients and that they are ultimately responsible for charges incurred due to a missed appointment. _____ **(initial)**

3. We understand that there may be circumstances that are beyond your control and we will try to accommodate them as best we can. However, there is a **24 hour cancellation** policy. You can cancel or re-schedule your appointment anytime 24 hours **before** your appointment. If the appointment is cancelled less than the 24 hour period or missed completely without notification the following consequences apply:

   a) If the first appointment is missed or if the cancellation is less than 24 hours prior to the appointment, there is no cancellation charge but a credit card is required to be on file prior to the next appointment. *Our office will notify you of this change* _____ **(initial)**

   b) If a second appointment is scheduled and missed or the cancellation is less than 24 hours prior to the appointment, there is a cancellation charge of $105. *Our office will notify you of this charge*. _____ **(initial)**

   c) If a third appointment is scheduled and missed or the cancellation is less than 24 hours prior to the appointment, there is a cancellation charge of $105 AND future appointments will no longer be made without approval of the doctor or office manager and outstanding fees or balances rectified. *Our office will notify you of these changes.* _____**(initial)**

CREDIT CARD POLICY

1. The patients' credit card information will be provided to the office and charged the next business day for the missed appointments and other fees incurred during treatment. _____ **(initial)**

2. Your credit card is used exclusively for charges incurred in the office. This includes any office charges that are current or outstanding. _____ **(initial)**

3. Unfortunately, services cannot be rendered unless valid credit card information is provided. ___ **(initial)**

I have read the above and agree to its terms and conditions.

Patient name or guardian Date

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

PAYMENT POLICY

Payment is expected at the time services are rendered. We accept cash, checks or credit cards. Delinquent accounts will be sent for collection, unless prior financial arrangements have been made. There is a **$25.00 service charge** on all returned checks. _____ **(initial)**

INSURANCE BILLING INFORMATION

Insurance billing slips are provided at the end of each visit. Included is all the information you will to submit to your insurance company to obtain reimbursement. Simply attach these billing slips or "Superbills" to the claim form provided by your insurance company and mail them in your reimbursement. Insurance reimbursement is an agreement between you and your insurance company. We will assist you in obtaining you insurance benefits. However, you are financially responsible for all charges, regardless of insurance coverage. _____ **(initial)**

WRITTEN REPORTS

Occasionally, requests are received for reports, treatment reports for insurance companies, and written evaluations to be sent to individuals or agencies. You will be billed for the time required to complete such reports, as well as clerical costs**.** _____ **(initial)**

I have read the above and agree to its terms and conditions.

_____

Patient name or guardian Date

_____

Printed Name

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

AUTHORIZATION TO RELEASE MENTAL HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition:

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

_____
Printed Name

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

MEDICATION REFILLS
INCLUDING TRIPLICATE PRESCRIPTIONS

The following policies are designed to improve the efficiency of the office and communication between you and the staff. Please **read, initial each statement** and **sign** at the bottom of the page to indicate **your understanding** of the policies.

It is your responsibility to fill your prescription before you run out of medications, and to protect your medications and controlled substances as carefully as you would your money or jewelry. There will be no refills of narcotic medication prior to the appropriate time. This is usually about 5 days prior to the next scheduled refill date. **_____ (initial)**

Triplicate prescriptions for controlled substances constitute an even more burdensome medico-legal and administrative responsibility. I do not prescribe addicting medications (medication with high abuse potential) for patients with a history of substance abuse, particularly those that the patient has already abused. Also, we do not refill lost, misplaced, stolen or otherwise unavailable addicting medication except under very special circumstances, and even then we make only one exception. It is your responsibility to fill your prescription before it expires. **_____ (initial)**

Reasons such as:

1. "I went out of town and left my medication behind when I returned home."
2. "The airlines lost my luggage which contained my medications."
3. "My spouse/roommate/girl or boy/friend/son/daughter/pet etc… stole my medication."
4. "I gave a few pills to my spouse/significant other….because he or she needed them."
5. "I opened my medication above the sink / toilet/ pool/ lake…..and it fell in."

are **not** valid reasons for early refills of medication, so please do not ask**!_____ (initial)**

Refill of prescriptions require periodic office visits with the doctor. It is important to comply with your scheduled doctor's visit to have a successful treatment plan. Standard medication management and follow-up is every 2 to 4 weeks or otherwise specified. Scheduled visits must be followed in order for the prescription(s) to be filled. **_____ (initial)**

Thank you for your anticipated cooperation.

I understand and will comply with these policies**._____ (initial)**

_____

Patient Signature or Parent/Guardian Date

_____

Printed Name

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

CONSENT TO TREATMENT

I, _____, voluntarily consent to Psychiatric care and routine diagnostic
Patient name

procedures as is necessary.

CONFIDENTIALITY: All information between physician and patient is held strictly confidential unless:

1) The patient authorizes release of information with a signature;

2) The physician is ordered by a court to release information;

3) The patient presents a physical danger to self or others;

4) Child abuse/neglect is suspected. In the two latter cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

I have read the foregoing, understand its content, and agree to the conditions stipulated herein.

_____ _____

Patient Signature Date

_____

Printed Name

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

NOTICE OF PRIVACY PRACTICES
(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability &Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how you health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care professionals. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20___ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices form this office.

You have recourse if you feel that your protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C., 20201
(202) 619-0257
Toll Free: 1-877-696-6775

I have read the above and agree to its terms and conditions.

_____

Patient name or guardian Date

_____

Printed Name

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

Frequently Asked Questions

Q: Do you accept Insurance?

NO – We are out of network for ALL insurances.

However, we can supply you with a superbill and you may submit it to your insurance if you desire. I recommend you contact your insurance company to find out if and how much they will reimburse you.

Q: How do I submit it to my insurance?

There is a customer service number on your Insurance card – call the number and tell them you need a claim form sent to you so that you can submit a bill. When you receive the claim form complete it using the information on the superbill that we gave you and return it to them for processing. I recommend you keep a copy for future reference.

Q: Why do you need a copy of my credit card?

The doctor prefers a credit card be on file for any missed appointment charges or in case you forget to bring payment at the time of the visit. This also helps to keep the office more efficient by spending less time with the collections process.

Q: What if I don't want to leave a Credit Card on file?

That's fine. We accept Cash Check or Credit Card for payment BUT payment IS EXPECTED at the time of your visit. Please be aware there will be a $25.00 charge for any returned checks.

Q: What if I have Medicare?

I'm sorry we can not take any Medicare patients. You can call the number on your Medicare card for referrals.

Q: What if I have Medicare but I am willing to pay out of pocket?

I'm sorry Medicare does NOT allow that.

Q: What if I forget my Check or credit card for payment?

Please call with a credit card or send a check or bring in payment BEFORE your next scheduled visit.

Q: I was charged for a missed appointment – why?

As explained in the paperwork you filled out at your initial visit, you are responsible to cancel your appointment 24hours prior to the date and time. We can allow 1 courtesy missed appointment but ALL future missed appointments will be charged at FULL FEE.

Q: Why do we no longer take insurance?

Due to the amount of time it takes for reimbursement and the confusion about coverage of "Out of Network" claims along with the insurance companies relentless stall tactics it is no longer cost efficient for our office.

Q: Do we have Saturday or Evening appointments?

No. The doctor has additional responsibilities to the community and is unable to accommodate these times.

Q: If you do not take insurance why do you need a copy of my Insurance Card?

Most Insurance companies require authorization for many medications prescribed in our office. If we have a copy on file we can avoid lengthy delays in the process which takes between 24 and 72 hours.

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax

Biography

Ed S. Jesalva, M.D. has been in private practice in psychiatry for about 30 years, providing psycho diagnostic evaluations, psychopharmacotherapy, stabilization and acute management of adults and adolescents in an in-patient and out-patient setting. He takes a biological, psychological, social, and spiritual approach to treatment. As a diagnostician, he feels that it's important and significant to have accurate diagnoses of the patient to be able to have an effective treatment plan.

Dr. Jesalva was born in Manila, Philippines, by Orlando and Pacita Jesalva, MD. His family moved to the United States and was raised in Arlington Heights, IL. He received his Bachelor of Science degree in Chemistry from the University of Illinois, and then finished his medical degree at the UHS/Chicago Medical School. He moved to California where he did his internship and his Psychiatry training at Harbor General Hospital/UCLA Medical Center in Torrance, California. Dr Jesalva maintains an active out-patient practice in treating adolescent, adult and geriatric patients who suffer from mood disorders, anxiety disorders, ADD/ADHD, substance abuse, and dementias.

Dr. Jesalva has also been very active teaching in the community and has lectured on subjects ranging from Attention Deficit Disorder, Anxiety, Depression, Bipolar Disorder, and Psychopharmacology. He is currently an adjunct professor at Pepperdine University for the graduate program where he teaches students on psychopharmacology. He has held medical director positions at several hospitals including St. John's Regional Medical Center's Gero-Psychiatric Unit and Charter Hospital's Adult Psychiatric Unit.

He consults to various counseling centers where he interfaces with local therapists to discuss clinical and educational aspects of active cases. These counseling centers include Conejo Counseling Center, Community Counseling Group, New Beginning Counseling Center and Conejo Valley Mental Health Professionals Association.

He is currently married to his wife Sally and has 2 children, Jillian and Jeffrey.

Ed S. Jesalva, MD
Diplomate American Board of Psychiatry and Neurology
2659 Townsgate Road Suite 209
Westlake Village, CA 91361
805-374-1120 805-374-1124 Fax