NEW PATIENT PACKET

2022

Michael T. Ingram, Jr., M.D., M.S.

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PRACTICE POLICIES

Welcome! Agreement to the following terms and conditions is required for the patient ["you" or "your"] to receive psychiatric services from Dr. Michael T. Ingram, Jr., M.S., M.D. ["provider" or "me" or "my" or "I" or "we" or "our"]. If you do not agree, I will be glad to give you referrals to other providers.

CLINICAL SERVICES

You are providing consent to receive a comprehensive diagnostic assessment. At the end of the evaluation, we will mutually decide if we will continue treatment together.

If you are in a life threatening medical and/or psychiatric emergency or you are a threat to public safety, you agree to call 911 immediately or go to the nearest emergency room. For non life-threatening inquiries please feel free to reach me anytime between 9am and 6pm by phone, email, or luminello messaging. Please know I will do everything I can to respond as soon as possible. You can expect a response within 48 hours.

Note that I do not have admitting privileges, nor am I affiliated with or on staff at any hospital. Should I deem more intensive services are needed than I can provide, I will do my best to ensure safety and obtain the appropriate level of care, but I cannot provide that care directly and cannot guarantee the receipt or quality of care that others provide.

All communication and clinical treatment will be documented in the patient chart. Both the law and the standards of the profession require such. You are entitled to receive a copy of these records unless I believe that seeing them would be emotionally damaging. If this is the case, I will be happy to provide the records to an appropriate mental health professional of your choice or to prepare an appropriate summary instead. Because client/patient records are professional documents, they can be misinterpreted and can be upsetting. If you wish to see the records, it is best to review them with me so that we can discuss their contents.

IF YOU ARE SEEING ME FOR MEDICATION MANAGEMENT:

- You agree to contact your therapist first (if applicable) for any psychiatric emergency or crisis, unless it is related to medication. If the emergency or crisis is related to medication, you agree

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to contact me immediately. HOWEVER, if you are experiencing a life threatening medical and/or psychiatric emergency, you agree to dial 911 or go to the nearest emergency room.

- You agree to inform me if you are considering stopping therapy, or have actually stopped
- You agree to see me in person or via telemedicine video conferencing at LEAST once per month for the first three months. After the first three months, you agree to see me in person or via telemedicine video conferencing at LEAST once every three months.
- You understand that medication refills will not be provided unless you've attended a scheduled appointment within the previous three months.

IF YOU ARE BEING PRESCRIBED A SCHEDULE I, II, III, IV, AND/OR V MEDICATION:

- You agree to see me in office or via telemedicine video conferencing ***AT LEAST*** once every two months.
- You understand that refills for scheduled/controlled medications will not be provided unless you've attended a scheduled appointment within the previous two months.
- You agree to see me in office (i.e., in-person) ***AT LEAST*** twice per year.

TELEMEDICINE & ELECTRONIC PRESCRIBING

If using Telepsychiatry services, electronic prescribing is available. In compliance with federal and state law, all patients prescribed scheduled/controlled medications must be seen IN-PERSON AT LEAST ONCE per year to continue receiving prescriptions.

DEFINITION OF CONTROLLED SUBSTANCE SCHEDULES

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules. An updated and complete list of the schedules is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§1308.11 through 1308.15. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused. Some examples of the drugs in each schedule are listed below.

SCHEDULE I CONTROLLED SUBSTANCES

- Substances in this schedule have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

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- Some examples of substances listed in Schedule I are: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ("Ecstasy").

SCHEDULE II/IIN CONTROLLED SUBSTANCES (2/2N)

- Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.
- Examples of Schedule II narcotics include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®). Other Schedule II narcotics include: morphine, opium, codeine, and hydrocodone.
- Examples of Schedule IIN stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®).
- Other Schedule II substances include: amobarbital, glutethimide, and pentobarbital.

SCHEDULE III/IIIN CONTROLLED SUBSTANCES (3/3N)

- Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.
- Examples of Schedule III narcotics include: products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®).
- Examples of Schedule IIIN non-narcotics include: benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as Depo®-Testosterone.

SCHEDULE IV CONTROLLED SUBSTANCES

- Substances in this schedule have a low potential for abuse relative to substances in Schedule III.
- Examples of Schedule IV substances include: alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

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SCHEDULE V CONTROLLED SUBSTANCES

- Substances in this schedule have a low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics.
- Examples of Schedule V substances include: cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC®, Phenergan with Codeine®), and ezogabine.

PLEASE NOTE

NO SERVICES WILL BE PROVIDED UNTIL PAYMENT IS MADE IN FULL. NO EXCEPTIONS.

IF YOU ARE SEEING ME FOR PSYCHOTHERAPY ONLY:

- You agree to contact me for any emergency or crisis, unless it is medication related. If the emergency or crisis is related to medication, you agree to contact the provider who is prescribing the medication first. HOWEVER, if you are experiencing a life threatening medical and/or psychiatric emergency, you agree to dial 911 or go to the nearest emergency room.
- You agree to inform me if you are considering stopping therapy, or have actually stopped
- You agree to see me in person or via telemedicine video conferencing as you prefer. There is no follow up requirement if you are seeing me for psychotherapy ONLY.

I RESERVE THE RIGHT TO STOP OR DISCONTINUE PRESCRIBING ANY MEDICATION(S) FOR ANY OF THE FOLLOWING REASONS AT ANY TIME:

- The policies outlined above are violated

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- Based on my professional and clinical judgement, there is a medical or psychiatric contraindication that necessitates stopping or discontinuing any medication(s)
- Continuing any medication(s) pose(s) a significant risk to your physical or mental health that is not outweighed by potential benefits.
- Based on my professional and clinical judgement, there is suspicion of abuse or diversion of medications prescribed for you.

I RESERVE THE RIGHT TO DISCONTINUE OR TERMINATE CARE FOR ANY OF THE FOLLOWING REASONS AT ANY TIME:

- The policies outlined above are violated
- Violation(s) of the Payment Policy Agreement (see below)
- Lack of adherence in treatment which, in my clinical judgement, poses a medical or psychiatric danger necessitating termination of care and/or referral to another provider(s)
- Inappropriate conduct, abuse, or harassment
- Appointments are repeatedly rescheduled, canceled, or you do not attend appointments.
- It has been over 12 months since you've been seen by Dr. Ingram.

NOTE: If care is terminated by Dr. Ingram, you will be provided enough psychotropic medication, if applicable, to last no more than thirty (30) days. It will be your responsibility to find a new provider.

RISKS AND BENEFITS OF PSYCHOTHERAPY

Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events. Potential benefits include a reduction in feelings of distress, better relationships, better problem-solving and coping skills, and resolution of specific problems. Given the nature of psychotherapy, it remains an inexact science and no guarantees can be made regarding the outcome.

CONFIDENTIALITY

There is no guarantee of confidentiality under the following conditions:

PATIENT INITIALS _____

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- If I suspect you are in imminent danger of harm to self or others, or a child or elderly person is being abused or neglected (as I am a mandated reporter).
- If a court orders a release of information
- If you initiate a malpractice lawsuit, or a billing dispute with a financial institution
- If you pay by credit card, my name will appear on your credit card statement
- If you do not pay your bill, your balance due statement (including diagnostic and procedural codes) may be sent to a collections agency or other responsible party
- Between me and my administrative staff
- With your written permission only: between colleagues with whom I consult professionally.
- If you use text messaging or email to contact Dr. Ingram or his Administrative Assistant which is NOT a HIPAA Compliant means of communication
- If you call Dr. Ingram or his Administrative Assistant by phone which is NOT a HIPAA Compliant means of communication

COVID-19

Due to COVID-19, masks will be required for all in-office visits for all unvaccinated patients. If you've been vaccinated per the CDC guidelines, you are not required to wear a mask.

SCHEDULING APPOINTMENTS

Please be sure to schedule a follow up visit in advanced. Last minute appointment requests may not be fulfilled as appointment slots fill up quickly. In the event of an emergency or crisis, you are instructed to go to the nearest emergency room and/or call 911 immediately.

NO SURPRISE BILLING STATEMENT

DR. MICHAEL INGRAM PROVIDES A FEE-FOR-SERVICE MODEL OF CARE

Dr. Michael Ingram isn't in your health plan's network. This means Dr. Michael Ingram doesn't have an agreement with your plan. The purpose of this statement is to let you know about your protections from unexpected medical bills. Receiving care from Dr. Michael Ingram could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

UNDERSTANDING YOUR OPTIONS

You are always welcome to receive care from other providers who are in-network with your health plan. Please contact your insurance company for a list of providers in-network. For more information about your rights and protections, please visit https://www.cms.gov for more information about your rights under federal law.

STATEMENT ON DIAGNOSIS IN PSYCHIATRY

While a thorough diagnostic evaluation at the initial consultation visit provides Dr. Ingram with enough information to make one or more "provisional" diagnoses, it is important to remember that accurate diagnoses in psychiatric medicine develop over time (i.e., weeks to months) as Dr. Ingram gets to know his patients and their behavioral patterns. When appropriate, diagnoses will be given but should be viewed as provisional and subject to change. That is, diagnoses can evolve and change over time as new symptoms and patterns emerge.

Dr. Ingram is primarily concerned with each individual's unique experience given that diagnoses do not adequately describe the complexity of a human being.

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PATIENT ATTESTATION

By signing below, you confirm you have read the "Michael T Ingram Psychiatry Inc Practice Policies" and you agree to all of the terms and conditions.

PATIENT NAME (PRINT)	PATIENT'S LEGAL GUARDIAN, IF APPLICABLE (PRINT)

PATIENT OR LEGAL GUARDIAN SIGNATURE	DATE

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PAYMENT POLICY AGREEMENT

This Payment Policy Agreement is designed to help Dr. Ingram provide the most efficient and reasonable health care services. Therefore, it is necessary to have a Payment Policy Agreement stating Dr. Ingram's requirements for payment for services provided to patients.

DR. MICHAEL INGRAM PROVIDES A FEE-FOR-SERVICE MODEL OF CARE

You agree to pay for services and fees as outlined in this PAYMENT POLICY AGREEMENT section. You are responsible for full payment, whether your insurance company ends up paying partially, or not at all, for services rendered. I do not communicate with insurance companies directly.

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT:

- Insurance pays for any services
- We decide to proceed with treatment
- Treatment is successful, for which there cannot be any guarantee

Dr. Ingram is considered an "Out-of-Network" Provider. Some insurance companies will pay for services from "Out-of-Network" Providers, but there is no guarantee that your insurance company will pay for services. You are responsible for paying the total amount billed for each session, regardless of whether your insurance company pays. Dr. Ingram does not accept Medicare or Medi-Cal as forms of payment (Non-Participating Provider).

Furthermore, Dr. Ingram is not responsible for any communication with insurance companies. This includes, but is not limited to, generating insurance claims, disputing reimbursements, or completing prior authorization forms for medications, laboratory studies, or other diagnostic studies recommended by Dr. Ingram. You will be able to generate an insurance claim for yourself through Luminello, Inc., the electronic medical record (EMR) system used by Dr. Ingram. If needed, Luminello has a user- guide to help you generate an insurance claim that you can submit to your insurance company.

There is no guarantee that your insurance company will reimburse you for the services provided by Dr. Ingram. You will be considered a self-pay patient during the entire course of treatment with Dr. Ingram.

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Payment is due at the time of your scheduled appointment. No services will be provided until payment is received.

INITIAL DEPOSIT

A deposit equal to half the initial consultation fee will be required to reserve your initial consultation visit. This deposit will not be refunded. Cancellations made within 24 hours of your initial consultation visit will result in forfeit of the initial consultation fee. Please note that rescheduling an initial consultation visit will not result in forfeiting of the initial consultation fee if you keep the appointment.

RATES

- **Initial Consultation Visit, (75 Minutes).....$975.00****
- **Follow Up Visit, (45 Minutes).....$500.00****
- **Follow Up Visit, (25 Minutes).....$350.00****
- **Follow Up Visit, (15 Minutes).....$275.00****
- **Phone Call Consultations/Visits.....$10.00/min****

Unless other arrangements have been made, the rates above apply.

PHONE CALLS, TEXT MESSAGES, PAPER WORK, AND ADMINISTRATIVE WORK

All phone calls and/or paper work requested outside of your scheduled appointment will be charged at a rate of $10.00/min. This includes obtaining collateral information from previous and/or current healthcare/mental health providers, family members, friends, and coordination of care. No phone calls or administrative work will be completed without your consent. That is, you will be billed ONLY for services you provided consent for.

LUMINELLO MESSAGING

Messaging Dr. Ingram directly via Luminello messaging will remain free of charge. If you have questions that cannot be answered in a quick response, please schedule a follow up visit by phone or telemedicine using the online scheduling tool or by calling/texting Dr. Ingram's Administrative Assistant at 949-436-9099.

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PROFILE INFORMATION AND CREDIT CARD/DEBIT CARD INFORMATION

Please be sure to keep your profile up to date. If you have a change of address, email, insurance, phone number, or emergency contact, please update this in your Luminello profile. An up-to-date Credit Card or Debit Card is required at all times. Please keep this updated by using the "billing" tab within your portal.

The rates (prices) listed above will not change for the first 12 months of treatment, which begins on the day of your initial consultation visit and ends exactly 12 months after the day of your initial consultation visit. After the initial 12 months of treatment, rates (prices) for services may increase. You always have the option of discontinuing treatment with Dr. Ingram at any time and he will offer you referrals upon request.

NOTE: If it has been over 12 months since you've been seen for a follow up visit, then another consultation visit will be required to continue receiving treatment from Dr. Ingram.

ACCEPTED METHODS OF PAYMENT

- ***Cash**
- ***Personal Check or Money Order made payable to:** Michael T. Ingram, Jr., MD
- **Venmo:** [@michael-ingram-7]
- **Zelle:** [mtipsychiatry@outlook.com]
- **Credit Card/Debit Card/HSA Card:** Luminello Portal

Cash, Checks, and Money Orders should be mailed to: 8271 Melrose Avenue, Suite 110, Los Angeles, CA 90046

****If you are using a health savings account (HSA) or flex debit card please check with your insurance provider as many HSA accounts may not allow processing through Luminello, Venmo, PayPal, etc.***

As you know, it is Dr. Ingram's policy to receive payment prior to your scheduled visit. No services will be provided until payment is received. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. If you have questions about your treatment plan or

the choice of payment options, please do not hesitate to ask. We are here to help you receive the healthcare you deserve.

PROCESSING FEES

If you choose to pay by PayPal, Credit Card, or Debit Card, then an additional processing fee of 3.99% will be charged in addition to the full fee of the visit.

GENERATING A BILLING STATEMENT

You can generate your own insurance claim to submit to your insurance company for reimbursement by going to "Billing" and "Create Statement". If needed, we are happy to do this for you and send to you as a PDF.

SUMMARY OF POTENTIAL FEES

WHAT ARE ALL THE POTENTIAL FEES YOU COULD INCUR DURING TREATMENT WITH DR. INGRAM?

1. **CANCELLATIONS/NO SHOWS:** Not showing up to a scheduled appointment AND/OR canceling an appointment within 48 hours of your scheduled follow up appointment will result in your credit card or debit card being charged for the full rate/fee of the visit. If you are running late, please notify us immediately. If you are not at your appointment within 10 minutes after your scheduled appointment time, then your appointment will be canceled, and you will be charged the cancellation/No Show Fee.
2. **INITIAL DEPOSIT:** A deposit of half the initial consultation fee will be required to reserve your initial consultation visit. This deposit will not be refunded. Cancellations made within 24 hours of your initial consultation visit will result in forfeit of the initial consultation fee. Please note that rescheduling an initial consultation visit will not result in forfeiting of the initial consultation fee if you keep the appointment.
3. **SCHEDULED APPOINTMENTS:** Appointments are charged based on duration. Rates for appointments are listed above.
4. **ADMINISTRATIVE WORK:** All phone calls and/or paper work requested outside of your scheduled appointment will be charged at a rate of $10.00/min. This includes obtaining collateral information from previous and/or current healthcare/mental health providers, family members, friends, and coordination of care. No phone calls or administrative work will be completed without your consent. That is, you will be billed ONLY for services you provided consent for.

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CREDIT CARD | DEBIT CARD INFORMATION

WHY DO YOU HAVE TO PROVIDE DR. INGRAM WITH YOUR CREDIT CARD OR DEBIT CARD INFORMATION?

Your Credit Card or Debit Card information is kept in your secure Luminello patient portal for the entire duration of treatment. Unless other arrangements have been made, your credit card or debit card will be charged for the initial deposit (see below), the initial consultation, each visit (see rates above), administrative work, and/or for cancellation/No Shows.

CHOOSE ONE: ☐ CREDIT CARD ☐ DEBIT CARD

CHOOSE ONE: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER ☐ OTHER

NAME ON CARD: _____

CARD NUMBER: _____ **CARD EXPIRATION DATE (xx/xxxx):** _____

CVV (THREE OR FOUR DIGIT NUMBER ON BACK OF CARD): _____

BILLING ADDRESS: _____

(Number, Street, City, State, Zip, Country)

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PATIENT ATTESTATION

By signing below,

- **I, the patient, have read and understand this "Payment Policy Agreement" and I agree to its terms and conditions. In the case that my insurance does not reimburse for services provided by Michael T. Ingram, Jr., M.S., M.D., I understand that I am responsible for payment of all services rendered.**
- **I affirm I am an authorized user of the credit card or debit card whose number, expiration date, CVV, and billing address are provided in this form, and I do authorize its use for all fees as outlined in all parts of this form.**
- **I acknowledge that I am consenting of my own free will and am not being coerced or pressured.**
- **I understand that I'm giving up some consumer billing protections under federal law.**
- **I understand that I will pay in full for the services provided by Dr. Ingram**
- **I understand that I was given a written notice explaining that Dr. Ingram isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by Dr. Ingram.**
- **I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.**
- **I understand that I can end this agreement by notifying Dr. Michael Ingram in writing before receiving services.**
- **I understand that I don't have to sign this form. But if I don't sign, Dr. Ingram will not treat me.**
- **I understand that I am always welcome to receive care from a provider or facility in my health plan's network.**

PATIENT NAME (PRINT) **LEGAL GUARDIAN, IF APPLICABLE (PRINT)**

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

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RELEASE OF INFORMATION FORM

PATIENT FULL NAME (FIRST, MIDDLE, LAST) **PATIENT DATE OF BIRTH (xx/xx/xxxx)**

PATIENT HOME ADDRESS **PATIENT PHONE NUMBER** **PATIENT EMAIL**

I GIVE DR MICHAEL INGRAM PERMISSION TO DISCUSS MY MEDICAL AND MENTAL HEALTH HISTORY WITH THE FOLLOWING INDIVIDUALS/INSTITUTIONS. EXAMPLES INCLUDE PREVIOUS PSYCHIATRISTS, CURRENT THERAPIST, PRIMARY CARE PROVIDER, OTHER HEALTHCARE PROVIDERS, FAMILY MEMBERS, FRIENDS, ETC. (If none, write NONE):

_____ _____

_____ _____

I GIVE THE FOLLOWING INDIVIDUALS/INSTITUTIONS PERMISSION TO RELEASE MY MEDICAL AND/OR MENTAL HEALTH RECORDS TO DR MICHAEL T INGRAM MD. EXAMPLES INCLUDE PREVIOUS PSYCHIATRISTS, CURRENT THERAPIST, PRIMARY CARE PROVIDER, OTHER HEALTHCARE PROVIDERS, FAMILY MEMBERS, FRIENDS, ETC. (If none, write NONE):

_____ _____

_____ _____

By signing your name in the space provided, you are giving Dr. Michael T Ingram, Jr. permission to contact the above-named individuals/institutions for the purpose of discussing and/or obtaining your mental health history and medical health history. You understand that this form is valid until you specifically state in writing that you no longer give Dr. Michael T. Ingram, Jr. permission to do the above.

PATIENT NAME (PRINT) **LEGAL GUARDIAN NAME, IF APPLICABLE (PRINT)**

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

PATIENT HEALTH INFORMATION (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

HOW WE USE YOUR PATIENT HEALTH INFORMATION (PHI)

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

INDIVIDUAL RIGHTS

You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in

notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address. In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

OUR LEGAL DUTY

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the patient portal on Luminello (Electronic Medical Record System). You can also request a copy of our Notice at any time.

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If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Please sign your full name below to acknowledge that you have read this form, you understand this form, and you agree with the contents of this form.

PATIENT NAME (PRINT) **LEGAL GUARDIAN NAME, IF APPLICABLE (PRINT)**

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

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TELEMEDICINE CONSENT FORM

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. Doxy.me is the software used by Dr. Michael T Ingram, Jr.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and medical record data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to visit with his/her psychiatrist [Dr. Michael T Ingram, Jr.] while at a remote location.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

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- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of video, images, or sound) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the software, network connection, and/or equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, YOU ("THE PATIENT") UNDERSTAND THE FOLLOWING:

- You understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without your consent.
- You understand that you have the right to withhold or withdraw your consent to the use of telemedicine in the course of your care at any time, without affecting your right to future care or treatment.
- You understand that you have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- You understand that a variety of alternative methods of medical care may be available to you, and that you may choose one or more of these at any time. Dr. Michael T. Ingram, Jr. has explained the alternatives to your satisfaction.
- You understand that telemedicine may involve electronic communication of your personal medical information.
- You understand that it is your duty to inform Dr. Michael T. Ingram, Jr. of electronic interactions regarding your care with other healthcare providers.
- You understand that you may expect the anticipated benefits from the use of telemedicine, but that no results can be guaranteed or assured.

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- You understand that you must be physically located within California to be seen for initial consultation over Telemedicine. After initial evaluation, Telemedicine follow up may be received outside of California if needed.
- You have read and understand the information provided above regarding telemedicine, have discussed it with your physician or such assistants as may be designated, and all of your questions have been answered to your satisfaction. You hereby give informed consent for the use of telemedicine.

YOU ("THE PATIENT") HEREBY AUTHORIZE DR. MICHAEL T. INGRAM, JR. TO USE TELEMEDICINE THROUGHOUT YOUR DIAGNOSIS AND TREATMENT.

_____

PATIENT NAME (PRINT) **LEGAL GUARDIAN NAME, IF APPLICABLE (PRINT)**

_____

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

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PATIENT CONSENT FOR TREATMENT

- ☐ I, the patient, voluntarily consent to any and all health care treatment and diagnostic procedures provided by Michael T. Ingram, Jr., M.S., M.D.
- ☐ I, the patient, am aware that the practice of medicine, especially Psychiatry, is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations provided by Michael T. Ingram, Jr., M.S., M.D.
- ☐ I, the patient, agree to be contacted via email, phone, or Luminello EMR messaging system with information related to my visit, like: a patient portal invitation, medication and lab orders, requests to fill out forms, financial or payment information, pre-visit surveys, post-visit surveys, or appointment reminders.
- ☐ I, the patient, consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered to me, treatment, and health care operations consistent with both the Notice of Privacy Practices and Payment Policy provided by Michael T. Ingram, Jr., M.S., M.D.
- ☐ I, the patient, have either received a copy of the Notice of Privacy Practice or I have been provided easy access to the Notice of Privacy Practice and I agree with its contents.
- ☐ I, the patient, have either received a copy of the Payment Policy or I have been provided easy access to the Payment Policy and I agree with its contents.
- ☐ I, the patient, give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

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PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

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INITIAL PSYCHIATRIC QUESTIONNAIRE

PATIENT DEMOGRAPHIC INFORMATION

FIRST NAME, MIDDLE NAME, LAST NAME **DATE OF BIRTH** **GENDER IDENTITY**

HOME ADDRESS **PHONE NUMBER**

EMAIL ADDRESS

FOOD ALLERGIES (LIST FOOD AND ALLERGIC REACTION)

DRUG/MEDICATION ALLERGIES (LIST DRUG AND REACTION)

PREFERRED PHARMACY (NAME, ADDRESS, PHONE NUMBER)

PRIMARY CARE PROVIDER

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HISTORY OF PRESENT ILLNESS

Please explain the reason(s) for seeking mental health treatment.

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PSYCHIATRIC REVIEW OF SYMPTOMS

Which of the following symptoms have you experienced in the past three (3) months? (Check all that apply)

☐ Low mood	☐ Low motivation	☐ Insomnia	☐ Hypersexual	☐ Restlessness
☐ Low energy	☐ Lack of appetite	☐ Hypersomnia	☐ Trauma/Abuse	☐ Dissociation
☐ Weight loss	☐ Increased appetite	☐ Impulsivity	☐ Nightmares	☐ Lack of joy or interest in life
☐ Weight gain	☐ Physical pain	☐ Worrying/Anxiety	☐ Flashbacks	☐ Thoughts of hurting others
☐ Concentration problems	☐ Suicidal thoughts	☐ Panic Attacks	☐ Auditory hallucinations (hearing things that aren't there)	☐ Thoughts of harming yourself
☐ Forgetfulness	☐ Anger	☐ Intrusive Thoughts	☐ Visual hallucinations (seeing things that aren't there)	☐ Urge to harm yourself
☐ Worthlessness	☐ Irritability	☐ Compulsive hand washing, cleaning, counting	☐ Paranoia	☐ Urges to harm others
☐ Hopelessness	☐ Euphoria	☐ Low libido	☐ Rapid Mood swings	☐ Tics

☐ **OTHER (specify):**

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MEDICAL REVIEW OF SYMPTOMS

Which of the following symptoms have you experienced in the past three (3) months? (Check all that apply)

☐ Fever	☐ Vomiting	☐ Palpitations	☐ Increased sweating	☐ Tremors
☐ Chills	☐ Diarrhea	☐ Racing heart beat	☐ Muscle weakness	☐ Head Injury
☐ Weight loss	☐ Increased appetite	☐ Dizziness	☐ Urinary problems	☐ Balance/Coordination problems
☐ Weight gain	☐ Musculoskeletal pain	☐ Vertigo	☐ Sexual dysfunction	☐ Easy bruising
☐ Night sweats	☐ Constipation	☐ Lightheaded-ness	☐ Seizures	☐ Nosebleeds
☐ Vision changes	☐ Abdominal (Belly) pain	☐ Shortness of breath	☐ Changes in sense of smell	☐ Nerve pain/Neuropathy
☐ Headaches	☐ Bloody stools	☐ Cough	☐ Changes in taste	☐ Skin rashes/lesions
☐ Nausea	☐ Chest Pain on exertion	☐ Nasal Congestion	☐ Fatigue	☐ Muscle cramps
☐ Ringing in ears	☐ Sore throat	☐ Changes in hair	☐ Changes in nails	☐ Hair loss
☐ Hearing loss	☐ Eye Pain	☐ Difficulty swallowing	☐ Heartburn/Indigestion	☐ Bowel/Bladder incontinence

☐ **OTHER (specify):**

Has anyone else noticed a change in your behavior(s) in the past three (3) months?

Yes **No** **I don't know**

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SUBSTANCE USE HISTORY

☐ **NONE**

DRUG	DATE/AGE OF FIRST USE	DATE/AGE OF LAST USE	QUANTITY OF USE	FREQUENCY OF USE	ROUTE OF USE
ALCOHOL					
NICOTINE/TOBACCO					
CAFFEINE					
CANNABIS/MARIJUANA					
METHAMPHETAMINE					
OPIOIDS/OPIATES/HEROIN/FENTANYL (NOT PRESCRIBED TO YOU)					
BENZODIAZEPINES (NOT PRESCRIBED TO YOU) – Xanax, Klonopin, etc.					
COCAINE					
LSD					

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DRUG	DATE/AGE OF FIRST USE	DATE/AGE OF LAST USE	QUANTITY OF USE	FREQUENCY OF USE	ROUTE OF USE
PSYLOCYBIN (MAGIC MUSHROOMS)					
MDMA/ECSTASY					
KETAMINE (NOT PRESCRIBED TO YOU)					
SPICE, SYNTHETIC MARIJUANA					
BATH SALTS, SYNTHETIC CATHINONES, PHENCYCLIDINE (PCP)					
PRESCRIPTION DRUGS NOT PRESCRIBED TO YOU					

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PAST MEDICAL HISTORY

Have you been treated for any medical problems? (Check all that apply)

- ☐ **NONE**
- ☐ **Diabetes Mellitus Type I**
- ☐ **Diabetes Mellitus Type II**
- ☐ **Seizure Disorder/Epilepsy**
- ☐ **Chronic Obstructive Pulmonary Disease (COPD)**
- ☐ **Bronchitis**
- ☐ **Asthma**
- ☐ **Obesity**
- ☐ **Hypertension (i.e. high blood pressure)**
- ☐ **Dyslipidemia (i.e., cholesterol problems)**
- ☐ **Iron Deficiency Anemia**
- ☐ **B12 Deficiency**
- ☐ **Cancer**
- ☐ **Parkinson Disease**
- ☐ **Stroke**
- ☐ **Irritable Bowel Syndrome**
- ☐ **Chronic Pain**
- ☐ **Arthritis**
- ☐ **Autoimmune Disease (e.g., Lupus, Rheumatoid)**
- ☐ **Coronary Artery Disease**
- ☐ **Congestive Heart Failure**
- ☐ **Cardiac Arrythmia (e.g., atrial fibrillation)**
- ☐ **HIV/AIDS**
- ☐ **Lyme Disease**
- ☐ **Hyperthyroidism**
- ☐ **Hypothyroidism**
- ☐ **Polycystic Ovarian Syndrome (PCOS)**
- ☐ **Prostate problems**
- ☐ **Traumatic Brain Injury/Concussions**
- ☐ **Dementia (e.g., Alzheimer, Lewy body, vascular)**
- ☐ **Inflammatory Bowel Disease (e.g., Crohn's, UC)**
- ☐ **Other (please specify)**

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When was the last time you completed blood work/Lab?

- ☐ < 1 month ago
- ☐ 3-6 months ago
- ☐ 6-12 months ago
- ☐ >12 months ago

How often do you see your primary care provider?

- ☐ Weekly
- ☐ Monthly
- ☐ Yearly

CURRENT MEDICATIONS AND SUPPLEMENTS

Please list any medications or supplements you take. Include name, dose, and frequency

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PREVIOUS MEDICATION TRIALS

Please check all medications you have tried in the past

ANTIDEPRESSANTS	BENZODIAZEPINES	SLEEP AIDS/HYPNOTICS
☐ Sertraline (Zoloft)	☐ Clonazepam (Klonopin)	☐ Doxepin (Silenor)
☐ Fluoxetine (Prozac)	☐ Diazepam (Valium)	☐ Zolpidem (Ambien)
☐ Paroxetine (Paxil)	☐ Alprazolam (Xanax)	☐ Eszopiclone (Lunesta)
☐ Fluvoxamine (Luvox)	☐ Triazolam (Halcion)	☐ Zaleplon (Sonata)
☐ Citalopram (Celexa)	☐ Temazepam (Restoril)	☐ Suvorexant (Belsomra)
☐ Escitalopram (Lexapro)	☐ Lorazepam (Ativan)	☐ Melatonin
☐ Duloxetine (Cymbalta)	☐ Chlordiazepoxide (Librium)	☐ Ramelteon (Rozerem)
☐ Venlafaxine (Effexor)		☐ Diphenhydramine (Benadryl, Z-quil)
☐ Levomilnacipran (Fetzima)		☐ Trazodone (Desyrel)
☐ Mirtazapine (Remeron)		
☐ Vilazodone (Viibryd)		
☐ Vortioxetine (Trintellix)		
☐ Bupropion (Wellbutrin)		

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ANTIPSYCHOTICS	PSYCHOSTIMULANTS	MOOD STABILIZERS
☐ Quetiapine (Seroquel) ☐ Olanzapine (Zyprexa) ☐ Risperidone (Risperdal) ☐ Paliperidone (Invega) ☐ Lurasidone (Latuda) ☐ Ziprasidone (Geodon) ☐ Asenapine (Saphris) ☐ Haloperidol (Haldol) ☐ Chlorpromazine (Thorazine) ☐ Perphenazine ☐ Aripiprazole (Abilify) ☐ Brexpiprazole (Rexulti) ☐ Cariprazine (Vraylar)	☐ Dextroamphetamine (Zenzedi, Dexedrine Spansule) ☐ Dextroamphetamine-Amphetamine Mixed Salts (Adderall, Adderall XR) ☐ Lisdexamfetamine (Vyvanse) ☐ Methamphetamine (Desoxyn) ☐ Mydayis ☐ Modafinil (Provigil) ☐ Armodafinil (Nuvigil) ☐ Methylphenidate (Ritalin, Ritalin LA, Concerta) ☐ Dexmethylphenidate (Focalin, Focalin XR)	☐ Lithium ☐ Valproic Acid (Depakote) ☐ Topiramate (Topamax) ☐ Lamotrigine (Lamictal) ☐ Oxcarbazepine (Trileptal) ☐ Carbamazepine (Tegretol) **OTHER** ☐ Gabapentin (Neurontin) ☐ Clonidine ☐ Prazosin ☐ Pregabalin (Lyrica) ☐ Buprenorphine (Suboxone, Subutex) ☐ Naltrexone ☐ Varenicline (Chantix) ☐ Ketamine (infusions or intranasal spray

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PAST PSYCHIATRIC HISTORY

When was the first time you saw a mental health professional and what was the reason for seeking mental health treatment?

When was the first time you saw a psychiatrist?

When was the last time you saw a psychiatrist? (Please provide name of psychiatrist)

Have you ever been admitted to a psychiatric/Mental health hospital? (If so, please specify dates)

Have you ever participated in a residential drug rehabilitation program? (If so, please specify programs and dates)

Have you ever seen a therapist? (If so, please specify type of therapy if you know it)

Are you currently seeing a therapist? (If so, please provide name of therapist)

Have you ever attempted suicide? (If so, please specify dates and how you attempted)

Have you ever intentionally harmed yourself? (e.g., cutting, burning, hitting, biting)

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Have you ever struggled with an eating disorder? (If so, please specify)

SOCIAL HISTORY

MARITAL STATUS

- ☐ **Married**
- ☐ **Single**
- ☐ **Divorced/Separated**
- ☐ **Widowed**
- ☐ **Partnered**

Do you have children? If so, please specify number of children and their ages

Where do you live?

Who do you live with?

Have you ever been arrested?

Have you ever intentionally hurt someone else? If so, please specify

Have you ever received a DUI (Driving under influence of drugs or alcohol)? If so, please specify

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Are you employed?

What do you do for work?

Who would you consider your support system?

Have you ever been victim of abuse?

What was the last grade in school you completed?

In a few sentences, how would you describe your childhood?

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FAMILY HISTORY

Has anyone in your immediate or extended family ever attempted or completed suicide? If so, please specify relative and method

Has anyone in your immediate or extended family ever been diagnosed with a mental illness? If so, please specify relative and condition

	Alive?	Age (years)	Mental Health Condition(s)
Father			
Mother			
Sibling1			
Sibling2			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Aunt 1			
Aunt 2			
Uncle 1			
Uncle 2			

Additional Comments:

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ADDITIONAL COMMENTS

Please provide any additional information you believe would be important for Dr. Ingram to know.

PATIENT ATTESTATION

By signing your name below you certify that the information provided in this form is true and accurate to the best of your knowledge and that you provided the answers to the questions even if someone else helped you fill out the form.

PATIENT NAME (PRINT) **LEGAL GUARDIAN NAME, IF APPLICABLE (PRINT)**

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**