FAMILY & WELCOME PACKET

Windows of Opportunity, Inc &
The Offices of Dr. Chip Stone

Telephone/Fax: 888-742-7014 **Email:** Dr.ChipStone@GMail.com or JonelleAtDrStones@Gmail.com

Whether you have or have not visited with a psychiatrist before, I want this experience to feel different and so much better than what you may have expected. I hope it feels more relaxed, comfortable, and personal. In this office, you should soon find yourself laughing, smiling, and learning more about yourself and your strengths. And, outside it, you will be in a better place to apply new reflections, perspectives and other more useful ideas to your life.

The following pages are intended for patients and, if appropriate, their families. In this Welcome Packet you will find information about me, the office, the staff, and several pages requesting information about the person for whom treatment is sought.

Thank you for taking the time to go through it. It seems to have grown even longer in recent years, but I suspect that as you go through it, you will find that it raises (and even answers) some questions for you. You may even find yourself enjoying it a little. Certain parts of it may not apply to your current situation. If that's the case, it is completely ok to skip right on over them!

Once completed, simply bring the material with you to your first appointment, along with any fees that are required and questions that you may have.

I look forward to meeting you and working with you & together we'll fly through, what may be at this point in your life, your "*Window of Opportunity*"!

At your first appointment, you may be given Dr. Stone's and our staff members' direct telephone lines as well. Please know that the office management staff, primarily Jonelle, is often utilized to schedule appointments and return phone calls. Our nurse Krista may assist with calling in prescription refills or answering medication related questions. Anthony handles insurance billing and coding questions. Nevertheless, rest assured, you can still reach me directly when questions or problems arise.

Thank you and God Bless You. Rest Assured you are in good hands!

Welcome to the office of Dr. Chip Stone. We are pleased to offer you many of the latest strategies for improving the quality of your life, whether you are 7 or 97! Frequently, our external stresses can create havoc with the internal processes of our bodies. Our bodies and our minds respond to these external stresses at times appropriately and at times inappropriately. At times our outside world seems wonderful, yet we still feel overwhelmed, unsatisfied, or unfulfilled inside. Often, the framework through which we view the world, and our place in it, gets skewed and we change our thinking and behavior patterns in ways to accommodate. Our expectation of what we should be accomplishing is oftentimes not lived up to by our performance which then makes us feel even worse. The hidden danger is that our beliefs start to make us think that we can't do better, or feel better, or get past a seemingly insurmountable obstacle…the good news is **WE CAN**!

Unfortunately, our brains and bodies are not always our best friends. Sometimes we react with anxiety, sometimes with depression, sometimes with isolation. We may feel worried, sad, or we may just shut down. The good news is that healthy functioning at levels even greater than experienced before can be obtained. There is no guarantee & the journey may be long, but striking improvement can frequently be anticipated.

I often look at things as a series of small steps. If I move only a foot ahead today, I may not feel like I've moved far. But, if over the course of six weeks, I move one foot ahead everyday (or even learn to take more steps at a time), I have moved a vast distant! It is my hope that, with time, you too will feel a greater sense of accomplishment & empowerment and that in the process you'll be stronger, more equipped, and more alive…

My Background:

I grew up in Washington State. Family members suffered from Depression, Bipolar Disorder, ADHD, and Alzheimer's Disease. My family has dealt with the demons of Alcoholism, Autism, and Cancer. I learned to understand medical, mental and emotional problems from both a personal and professional point of view. I attended medical school at The University of New England in Maine and The University of Osteopathic Medicine and Health Sciences in Iowa. I was in an Internal Medicine Residency (high blood pressure, gastric ulcers, infections, diabetes, asthma, and heart disease) at Creighton University in Nebraska and completed my Psychiatry Residency at the University of Virginia in Charlottesville, Virginia. I then completed a Forensic Psychiatry Fellowship at UCLA before settling in Orange County.

Missed Appointments:

No one can be perfect. No one's memory is flawless. No one can predict emergencies or disasters. Courtesy is however, requested. The right is reserved to charge up to $300 for each appointment missed. 24 hours notice is appreciated & you will not be billed if you cancel with at least 24 hours notice. If you are running late, you will still have access to a full session if your appointment does not encroach upon another. That is a courtesy to you in case the person scheduled before you is running late…they will not affect your time.

Messages and Emergencies:

You will have my office number and have at least 60 seconds during which you may leave a detailed message. You may also have access to my direct line. If I am unavailable, I will leave directions for you on the office answering machine and may have notified you beforehand. If you have a life-threatening emergency, experience worry that you will hurt or kill yourself, or have a concern that you are going to hurt or kill someone else, please leave a message for me and call 911 immediately. I suggest leaving hospital emergency department, law enforcement, and poison control numbers by your telephone or programming them into your cell phone. You may also want to check with your insurance carrier to see which hospitals you will be covered at in case of an emergency. While I do not work in any hospitals, many dear friends do.

Office Service Fees:

Fees are to be paid at the time of service unless previous arrangements have been made. Checks, credit cards, or cash are accepted payment options. For private patients who wish to utilize the benefits of a PPO insurance company with whom our office does not have a contract, I am able to provide a receipt & a statement of service which you may submit to your insurance company allowing you to seek reimbursement from it. On some occasions, I may be able to bill an insurance company directly for you. For patients who wish to avoid notifying their insurance company for privacy reasons or because of concerns about increases in premium costs, I am able to work with you and without restriction. Additionally, bypassing insurance companies permits the content of our conversations to remain fully protected & confidential.

You will have access to a voice message pager and/or my direct line. I remain continuously dedicated to ongoing medical learning and thus you have access to the latest medication information and therapy strategies. You will have access to a resource for questions. Programs designed specifically for your individual needs will be available. You will have access to flexible evening hours, weekend availability, and the assurance of being seen quickly. We will work together to develop a treatment plan and strategy to meet your unique and individual needs. This may be unfamiliar to you, but you will likely be able to reach me directly and have a friendly and comforting voice respond quickly.

Initial Evaluation (60-75 minutes, with diagnostic impression, and treatment planning)	$475.00
Medication Management (15 minutes, primarily evaluating medication efficacy and side effects)	$125.00
Lunch-sized psychotherapy (25-30 minute support, strategies, w/ or w/o medication management)	$150.00 (estimate)
Dinner-sized psychotherapy (45-55 minute in depth psychotherapy with support w/ or w/o medication)	$270.00 (estimate)
Calling in prescriptions between appointments	$25.00
Letter Writing (estimate)	$55.00
Report Writing (estimate)	$95.00
Form Completion (estimate)	$85.00
Discussions by phone or phone sessions	$30.00/10min

**Co Payments or payments for services not covered by insurance will be due at the time of appointment.
**The fees for Home Visits vary and typically are $50.00 higher than those listed above.
**Retainer/Advance agreements are available and will typically save approximately 10% of your costs.
**5% of all fees may be donated to a charitable or religious organization of your choice.
**Patients are responsible to pay for services not typically covered by insurance at the time of scheduled appointment.

Confidentiality, Privacy, and Exceptions to the Rule:

Your personal information, things that are discussed between us and even whether you are or are not a patient are almost universally and invariably held in the strictest of confidence. There are rare exceptions to this rule. I will work closely with you to find a comfortable solution if any of these come up. The following are exceptions to confidentiality:

- ✓ Office staff who handle scheduling appointments, paperwork, or speaking with you on the telephone.
- ✓ Nursing or Facility staff that assists in caring for elderly or dependent persons (e.g. at an assisted living center).
- ✓ Insurance companies when patients agree to or submit claims for services or claims for reimbursement.
- ✓ Any need to contact authorities when, in reasonable professional judgment, a patient poses a danger to himself or herself either by neglect or by an active plan to commit suicide or engage in physical harm (this **does not** include high risk behaviors like mountain biking or even the recreational use of drugs…those things are still confidential). Interventions for people in the midst of a life-threatening crisis often include hospitalization on a locked unit equipped to minimize a patient's danger of harming or killing himself or herself.
- ✓ Also, if a patient poses an immediate threat or danger to another person as a result of a mental disorder, the psychiatrist has a duty to take reasonable steps to protect the target. That may include hospitalization of a patient, contacting police authorities, or contacting the person targeted.
- ✓ If there is reasonable cause to believe that a minor or an elderly person is being abused or neglected by a patient, the professional has a duty to take reasonable steps to protect as well. The same holds true if the patient is the victim of abuse and is not mentally capable of properly protecting him or herself.
- ✓ In legal proceedings where a patient's mental state is at issue, his or her records often become open to the courtroom and ultimately may become a matter of public record.

Please sign below to indicate that you have read, understand, and agree with the issues addressed in these first 2 pages. If the patient is a juvenile, a dependent elderly person, or on a conservatorship, please also have a responsible adult sign.

_____ (Patient Name) _____(signature)

_____ (Responsible Adult) _____ (signature)

Patient Background Information:

Name: _____ DOB:_____ SS# _____

Mailing Address: _____

Contact Number where a message can be safely left: _____

Additional Contact Number: _____

Email Address: _____☐I am aware that email is not entirely confidential, but I accept the risks to communicate with Dr. Stone's office about sensitive matters. ☐Ok for "non-sensitive matters only ☐I do not wish to use email to correspond.

Emergency Contact Person: _____

Marriage and Children Status: _____

Occupation/Employer: _____

Is your work/home life stable, chaotic, in flux? _____

How did you learn of the office? _____

Who referred you to the clinic? _____

Who is your Primary Care Doctor?_____

Medical Conditions: _____

Results of most recent physical exam: _____
Results of any studies done of the brain or other organs (CAT Scan/MRI): _____
Results of any important or recent blood tests: _____

If you are comfortable with the sharing of the information, please obtain reports or any other recent reports generated by your physicians or ask that copies be sent to Dr. Stone.

Current Medications & Vitamins: _____

Family History of Medical or Psychiatric Problems: _____
_____

Previous medications or treatments by a psychiatrist: _____

☐I receive talk therapy from _____ ☐I do not have a therapist. ☐Talk Therapy not needed

Pharmacy Used and Telephone Number: _____

Any drug allergies or side effects: _____

Any alcohol or drug problems of concern to yourself or others _____

Childhood Developmental Problems or delays: _____

_____

Person Responsible for Medical Decisions if not the patient: _____ Phone #: _____

Insurance Information Form:

If you would like our office to bill your insurance company directly, we indeed may be able to do that. Provided that you have Anthem Blue Cross, another Blue Cross Carrier, Cigna, Aetna, CHIPA, MHN, or a PPO Plan that participates in Multi-Plan Expedited Agreements [which you may check by contacting your insurance company or by calling Multi-Plan at 866-568-2928] our office may be able to bill directly for you and your out-of-pocket responsibilities would be then limited to things such as co-pays, co-insurance, deductibles, and payment for services not covered by insurance.

While in the past, I had worried that insurance companies would interfere with treatment and confidentiality, I can say that Aetna and Cigna appear to be quite easy to work with and conscientious of privacy. Blue Cross carriers, including Anthem, occasionally ask for authorizations, but the level of detail or personal history required is quite low. CHIPA is a bit more intrusive and patients with that insurance have found their records requested as a means of confirming medical necessity and as a measure of the quality of care they are receiving. Thus, given that one of the things that I value most in the relationship between doctor and patient is the your privacy, I will bend over backwards to protect your private and confidential information.

It should be noted that insurance companies, in order to process claims, do require things such as diagnoses and periodically have limits on the number of office visits that are permissible. And, an insurance company, when processing a claim at a pharmacy, will know the names of the medication that a person is prescribed. However, it is rare when this information is used to a patients detriment. Again, I would simply not permit any information to be shared that I believed could in anyway bring harm or retribution to you. And, that includes not simply information to insurance companies, but also to employers, courts, and even family members. In this office you, and your information, will always be handled with the utmost of privacy, protection, and confidentiality.

If you would like our office to therefore bill your insurance company directly, please complete the following information and submit it, ideally prior to your appointment date. If you do not have your insurance coverage confirmed at the time of your appointment, payment from you will be expected. [Reimbursement to you can always be completed at a later date.]

_____	_____	_____	_____
Insurance Co & Provider Line #	Group #	Policy #	Primary Insured Person & DOB

_____	_____	_____	_____
Patient Name	Patient DOB:	Address	Phone Number

I have authority to and do authorize Dr. Charles Stone to bill this insurance company for services and I understand the preceding information and agree in full with the procedure in place:

_____	_____
Signature	Date

The Goals I have for Treatment and/or Therapy:

These are the things that I would most like to work on accomplishing:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

These are the things that I think might be preventing me from accomplishing these things:

8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

My level of commitment (on a 0 to 10 scale) to accomplishing these tasks is: _____

By not accomplishing these things, my life is being affected in these negative ways:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Once I accomplish these things, I see my life getting better in these ways:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

When I think about having "therapy" with someone that I trust and with someone I know will keep the things I talk about private, I think I would prefer to do it: (select up to 3)

☐ walking the beach	☐ talking by phone	☐ in a larger medical office
☐ laying on a couch	☐ in a dimly lit room	☐ in a small office
☐ sitting in a chair	☐ in a bright room	☐ chatting by email

Patient's History

Please Fill in Briefly with Relevant Information about yourself or the patient for each of these categories. If there is important information that would be helpful for Dr. Stone to have, but is not specifically requested, please feel free to address that information on the back page.

1. **Description of the major features of your concern (symptoms, problems, what are the major issues, etc)**:

2. **What (if anything) has happened in your life that has triggered or added to these symptoms**?

3. **How have these concerning problems affected your life (e.g. marriage, work, parenting, relationships with friends, ability to have fun, sex life, sleep, appetite, weight changes, normal routine)**

4. **Who is in your current social support system? (E.g. Friends, Family, Roommates, Co-workers)**

5. What do you believe was important about your childhood and early developmental years? You can list what you remember as good, as bad? Do you think that any of that stuff may have contributed to your current state?

6. <u>Questions I have for Dr. Stone</u>:

Thank you for taking the time to complete these documents and bring them with you to your first appointment. You have begun the journey by taking this first step. I look forward to doing what I can in assisting you in beginning to live life to the fullest. Once again, welcome to what may be your Window of Opportunity.

C.F. "Chip" Stone, D.O.

CONFIDENTIALITY FORM

Patient Information and Request for Information Sharing with other Parties

Dr. Stone believes that confidentiality and trust are important in relationships he has with his patients. He is able to hold in confidence details of your visit, including diagnoses, treatment recommendations, and follow-up appointment plans. As you may be aware, information that creates an emergency (such as risk of harm or death to you or someone else) cannot always be held in the strictest of confidence, but Dr. Stone will work with you if these matters come up to provide you with the safest reasonable alternative.

Dr. Stone is happy to provide information to family members, other mental health professionals, and other physicians (such as a family doctor) if you request that such information be shared. However, it must be specifically requested or the delicate material will not be shared. Do not assume information will be shared. Assume it will not be shared, unless specifically requested.

If you would like to have Dr. Stone provide information discussed during your conversation with him, including his impressions, diagnoses, and recommended treatment plan to family members, other mental health professionals, or other physicians, please indicate that below. Your information will not be disclosed without your expressed written request and signed consent.

1. ___ I would **not** like to have my information disclosed to any other third party, including (but not limited to) members of my family, employers, other physicians, insurance companies and any other persons involved in my care. I understand that this request will be honored immediately. I can change my mind at any time and a new request will be honored beginning at that time.

2. ___ I would like Dr. Stone to provide **only** the following individuals, companies, employers, or medical offices with basic details regarding his impressions, diagnoses, and treatment recommendations: (please indicate names, relationship, phone numbers, and addresses if known)

a) _____

b) _____

c) _____

d) _____

3. If I requested that information be disclosed, I would prefer that it be disclosed in the following form [__ written __ verbal __ either]. If there is anyone on my list that I would prefer receives their information in a different format, I have indicated who they are and the format I wish to have them receive the information below:

_____

4. I understand that what I have decided today is binding immediately, but may be changed anytime at my request. I know that for patients in a care facility, communication with nursing or care staff is often necessary. I also understand that in situations that pose a high risk of danger, either to myself or to someone else, Dr. Stone's professional judgment and duty may require that we modify this agreement. However, I understand that Dr. Stone believes that communication with me is important and that he will take reasonable steps to discuss with me any changes to this agreement that he believes would be in my best interest.

_____(signed) _____ (printed) _____ (date)

CONFIDENTIAL HISTORY:

This information will be held strictly confidential and your honest and true responses will be what will help you the best.

Please check the boxes that accurately or closely represent true feelings, thoughts, or behaviors:

☐Problems with reading things or understanding writing ☐Problems Doing Math or Managing $$
☐Repetitive Behaviors ☐Preoccupied with Odd things ☐Inattentiveness ☐Easily Distracted
☐Missing important parts of conversations ☐Not following through on tasks & things left undone
☐Missing important parts of instructions ☐Problems organizing life, chores, and/or activities
☐Losing things or misplacing things too frequently ☐Excessively forgetful ☐Talks too much
☐Hyperactive Behaviors ☐Impulsive outbursts ☐Interrupts other people a lot ☐Can't sit still
☐Angry outbursts ☐Getting into fights/arguments ☐stealing things ☐Lying ☐Running away
☐Skipping school ☐Disrespects people in authority ☐Nervousness when separated from others
☐Excessive fears of losing attachments ☐Trouble sleeping w/o an adult or stuffed animal present
☐Refusing to go to school/work ☐Fluctuation of Mental Clarity/Confusion ☐Speech Problem
☐Memory Problem ☐Not recognizing familiar people/things ☐Problems managing daily events
☐Agitated Behaviors ☐Paranoid Reactions ☐A change in Personality ☐More Labile/unstable
☐More out of control ☐More "loose" ☐More aggressive ☐Less interested ☐More fearful
☐Using drugs to escape problems ☐Missing work because of problem ☐Hearing things or voices
☐Flashbacks to traumatic event or past drug state ☐Seeing things ☐People are trying to get me
☐Fear that people are reading or influencing my thoughts or actions ☐Being followed or poisoned
☐unstable moods ☐high sense of self-worth ☐low level of self-worth ☐spouse/SO is unfaithful
☐I'm a lot sicker than people know ☐feel sad a lot ☐feel empty inside ☐lost interest in things
☐angry ☐appetite changed ☐sleeping too much ☐I can't sleep ☐No energy ☐guilty feelings
☐I'm ashamed of things I've done ☐I'm very edgy ☐I can't get off the couch ☐I'm worthless
☐Indecisiveness ☐I'm going to kill myself ☐I've thought about it ☐I've cut or burned myself
☐My mood is unstable quite a lot ☐Other people think I'm strange or weird ☐I'm more cranky
☐I'm a risk-taker ☐I get a kick doing fun things that use a lot of adrenaline ☐I talk too much
☐I go out too often to dinner or dancing ☐Sex has gotten me into trouble ☐I spend too much $$
☐I don't think things through a lot of times ☐I'm always moving & working on a project or two
☐I worry a lot about my physical health ☐People would like me even better if they understood me
☐People admire me because of my knowledge and abilities ☐I'm a follower ☐I'm a leader
☐I get nervous and scared in a hurry without any reason, trigger or warning ☐ I'm going crazy
☐I don't leave the house much ☐I don't like crowds ☐Social gatherings make me uncomfortable
☐The worries I have are stupid ☐I think about things over & over ☐I purposely try not to worry
☐I'm on edge a lot ☐I think/dream about bad things from the past ☐I'm in a daze ☐restlessness
☐I have a lot of pain ☐I have stomach problems ☐I don't like my figure ☐I pull/pick skin/hair
☐Something bad recently happened in my life ☐I don't like being alone ☐I keep too much stuff
☐I can be stubborn when it comes to rules ☐I've done great things no one seems to appreciate
☐I prefer being alone ☐I like being center of attention ☐I over-estimate how much people care

Medical Issues:

☐Chest Pain ☐Heartbeat ☐Sweating ☐Vision Problems ☐Muscle Tightness ☐Weakness
☐Hot Flashes ☐Always Feel Cold ☐Fever ☐Joint Pain ☐Neck or Back Pain ☐Coughing
☐Wheezing ☐Short of Breath ☐Coughing up blood or sputum ☐Sore throat ☐Runny Nose
☐Eye pain ☐Skin Rash ☐Nausea ☐Digestion Problem ☐Constipation/Diarrhea ☐Heartburn
☐Headache ☐Urine Retention ☐Burning pain when urinating ☐slow urine stream ☐Tremors
☐Dizziness ☐Numbness/Tingling ☐Fatigue ☐Seizures/Fits ☐Always thirsty ☐Weight Gain
☐Weight Loss ☐I am Pregnant ☐I am considering or at risk of becoming Pregnant ☐Cigarettes

Patient/Physician Treatment Contract/Agreement:

An agreement to enter into a treatment relationship brings with it unique responsibilities for doctors and patients alike. It is imperative that neither physician nor patient feel pressured or coerced into a particular treatment and it is similarly vital that both play an active and involved role in the decision making that takes place in selecting a treatment approach. This legally-binding agreement represents the expectations that patients (and/or patients' representatives) have when entering into a treatment relationship with Dr. Charles "Chip" Stone. Many of these expectations include and are formed on the basis of mutually active participation in treatment decisions, communication, and cooperation in the care of the patient. This requires an open, trusting, and safe environment.

As a clinical and forensic psychiatrist, I provide diagnostic evaluations, individual and family psychotherapy, psychological testing, consultation, and liaison with other professionals. I may discuss with you the potential benefits of adding another specialist in another area of medicine. I make recommendations to use medications when appropriate. At times, discussions during the course of therapy may be inaccurately interpreted to be a recommendation and thus, patients are encouraged to confirm their understanding of material discussed during therapy as well as clarify the treatment and therapeutic recommendations. For example, a discussion about a potential divorce, dropping out of school, or changing jobs should not be interpreted as a recommendation without clarification. Patients are encouraged to ask questions as well about any "homework" assignments.

My background and training after medical school includes one-year training in an Internal Medicine Residency and completion of both a General Psychiatry Residency as well as a Forensic Psychiatry Fellowship. I am licensed to practice medicine and surgery in the State of California, but limit my practice to psychiatry. I will, on occasion, refill non-psychiatric medications for patients that I know well or even prescribe medications such as antibiotics when clinically appropriate. I maintain an ongoing attitude of learning and am consistently involved in continuing medical education, staying abreast of new treatment strategies, and pursuing board certification in both General Psychiatry and Forensic Psychiatry.

Patients are encouraged to keep in mind that in the professional relationship established with Dr. Stone, recommendations for the use of therapy may or may not be made. Similarly, the recommendation for medication may or may not be made. Each patient is encouraged to discuss the rationale and the reasons for recommendations and similarly openly communicate thoughts and express their own creative ideas in the process.

Specifically, regarding medication treatments, each and every treatment carries with it risks, potential benefits, limitations, and alternatives. Dr. Stone will inform the patient about these respective issues with enough detail to permit a reasonable and responsible consent to be given. The patient's use of medication, strategies entertained during a therapeutic process, and integrating insight and other recommendations provided during the course of treatment with Dr. Stone are each fully voluntary; however, Dr. Stone will make recommendations when his professional opinion is that the patient's life will benefit from adherence. Consequently, not following recommendations may have deleterious, negative, and in the rarest, but worst situation, fatal, outcomes. Patients are expected to discuss their perspectives, concerns, understanding, confusion, disagreements, previous experiences, and alternatives with Dr. Stone. Remember the goal of both patient and physician alike is to reach for the maximum potential of feeling and functioning within the patient and within the sphere of his or her life.

It is important for patients to feel informed about the treatment process at every level, which includes therapy recommendations, diagnostic issues, education, medication issues, treatment goals and expectations, as well as prognosis. Part of this process includes discussing alternative approaches, the associated risks/benefits of treatment (or alternative treatments), an understanding that a desired treatment outcome is not guaranteed, and having an opportunity to ask questions. Realistic goals, expectations, and outcomes will be discussed.

Initial This Line to Represent Understanding & Acceptance of this Page: _____

Doctor/Patient Contact

In this treatment relationship, Dr. Stone will maximize your ability to make contact with him or his office staff via direct telephone contact, face-to-face contact in the office, email, video-conferencing, or by other agreed upon means. This contact will permit the patient to discuss progress and seek objective feedback, discuss potential side effects of medications, discuss important issues that evolve or occur in the interim between appointments, schedule follow-up office appointments, request medication refills, ask questions about an issue discussed during a previous therapy session, or any number of other issues that may arise. Our office staff members are frequently available to answer telephone calls directly and at all times there will be an answering machine or answering service that will take confidential messages and deliver them securely 24 hours a day. There may be occasions when neither Dr. Stone nor any members of the office staff are available for extended periods of time (e.g. training, conferences, vacations). In these cases, there will be another physician who will be professionally available, either directly or via his or her office staff. Dr. Stone does not provide emergency or hospital services, but has professional colleagues who do inpatient work. Dr. Stone recommends that patients keep 911, poison control numbers, and hospital numbers handy in the event of a crisis.

Confidentiality and Informed Consent

As described elsewhere, it can be anticipated that material discussed during the course of therapy is highly protected and confidential. The patient must feel free to convey feelings, express emotion, discuss concerns, and explain drives or urges without fear of reprisal. Thus, for example, even expressing urges to harm another person, is fully confidential, provided that it is not foreseeable that the urge is going to lead to an actual assault or harm. Similarly, even the discussion of illegal activity is protected and confidential, in a way similar to discussions with attorneys, provided that the activity is not going to lead to foreseeable harm to another person or has not harmed a person who is believed to be unable to protect himself or herself (e.g. a child or elderly person). Many of these issues may, however, become part of a discussion in therapy. Other limitations for confidentiality include:

1) When the patient or legal decision-maker requests exchange or release of information.

2) When a judge issues a specific order or in a lawsuit where mental condition is at issue;

3) Mandated reporting of suspected abuse of a child or elderly person.

4) When there is a reported or perceived threat to harm self or others; potential harm to others also requires by law that steps be taken to protect the potential victim, which may involve placing a patient in the hospital until the crisis, urge or risk has passed. In some circumstances, it may require notifying the targeted victim and/or the police.

5) For those who utilize third party reimbursement, information is often required and has been implicitly or explicitly agreed to already when the insurance policy was purchased.

It is my professional belief that children, particularly those over the age of 12, are entitled to confidentiality regarding the specific content of their therapy and treatment encounters. This represents an important component in the development of trust and a therapeutic alliance. Clearly, it is also important, however, for parents to receive general information on how treatment of their children is proceeding. If substantial concerns arise about a family member, I recommend that the concern(s) be addressed and resolved in the context of a family therapy session. If a parent (or family member) calls to provide me with information about the patient, please be aware that in the next therapy session, I will acknowledge that I received the phone call so that the patient is aware of the call. The exceptions to confidentiality previously described apply to children and adolescents as well.

Initial This Line to Represent Understanding & Acceptance of this Page: _____

Treatment & Financial Issues

Given the complexity of the human dimension, psychological, emotional, and psychiatric treatment involves the use of more than a single approach. There may be different interventions utilized at various points in time, each geared toward meeting the need of the patient. Services provided may include medication management, individual psychotherapy, family involved psychotherapy, medication refills, social skills training, academic-focused behavioral interventions, and other services.

The physician and the patient each have roles and responsibilities as discussed throughout this agreement. Additionally, it is anticipated that patients will commit to such things as:

1) making and keeping appointments routinely
2) remaining open and honest about feelings, behaviors, drawbacks, risks, and potential harm
3) changes in social, family, or occupational status
4) paying for services promptly and as agreed
5) Parents who bring children for treatment agree to bear financial responsibility for services provided to the child(ren).
6) Using medications appropriately and notifying me promptly of any reasoning for not using the medication as prescribed. There are certainly times when not using medications as prescribed is appropriate (e.g. when side effects are substantial).
7) actively participating in treatment

Special Fees

Please refer to the Fee Schedule of a listing of many of the professional fees. Payments are to be made at the time of each session, unless special arrangements have been made in advance. In the event of financial trouble, patients may be able to have fees or co-pays deferred; however, this requires promptly notifying Dr. Stone or a member of the office staff of the need. There may be additional fees associated with returned checks, copying and mailing clinical records if requested, attending sessions or meetings of clinical importance outside the office, or participation in legal matters. Coordination of care, either by phone or letter, with psychologists, primary care physicians, or places to which I refer will not typically incur costs and I do not charge for writing routine letters to pediatricians. Further, while I do not charge for routine phone calls, I do bill at my professional rate for extended phone calls, particularly when therapy is provided. As listed above, our office may charge a $25 fee for calling in prescriptions, although such charges are rare and typically extended as a courtesy to you. Notification of all pending fee changes will be made well in advance of any fee changes.

Medication Informed Consent

In those situations where medication is recommended, Dr. Stone will discuss the expected usefulness, the potential risks, and the potential alternatives. The patient is advised that psychiatric medications can be exceptionally helpful, but carry risks. While the risks are typically low and, in those cases where medication is recommended, it is expected that the benefits will significantly outweigh the risks. Nevertheless, risks such as diabetes, fainting, cholesterol problems, strokes, stiffness, seizures, rashes, drug interactions, infections, bleeding, liver problems, cardiac problems, kidney problems, metabolic disturbances, pancreatitis, and even mechanical obstruction leading to death can occur. The patient is expected to ask questions, seek clarification, understand the expected benefits, provide feedback, appreciate that change takes time, and actively participate in the decision-making. The patient understands that treatment is voluntary. The patient filling a prescription and/or using a medication confirms that he or she understands the information about the medication sufficiently to make a voluntary and informed decision to use the medication, knows there are alternatives, and accepts the risks.

Initial This Line to Represent Understanding & Acceptance of this Page: _____

Suicide (and Violence) Risks

Suicide is not a risk of every patient who seeks treatment from a psychiatrist. However, in certain conditions, such as bipolar disorder, personality disorders, depression, and schizophrenia a patient's risk of self-harm or suicide may increase. However, contributing to the risk are such things as past suicide attempts, social structure or support, family history of suicide, substance abuse, demographics, occupational status, marital status, financial issues, religious beliefs, hope for the future, and one's reasonable expectations for growth or improvement. Dr. Stone will assess suicide risk on an ongoing basis. Patients are expected to discuss with Dr. Stone when they perceive their risk of self-harm or suicide increasing. Patients will not conceal their plans or intentions to engage in self-harm or suicide. Patient acknowledges responsibility to notify Dr. Stone of any suicidal thoughts or urges. This is the only way that Dr. Stone can properly assess, address, treat, or care for the patient in such a situation. If Dr. Stone is not aware of a patient's thoughts or urges to commit suicide, he will not be in a position to fully treat or care for the patient. Thus, patient accepts responsibility to notify and recognizes that even the finest suicide risk assessment will be inaccurate if the patient knowingly and willfully withholds information from the physician.

Disputes, Disagreements, and Arbitration

This section of the **Patient/Physician Treatment Contract/Agreement** (as well as the section[s] pertaining to confidentiality) continues in force and executable and does not expire when and if the treatment relationship ends or terminates. This section does not have an end date. During the course of any relationship, conflicts, arguments, unintended outcomes, adverse effects, and controversy may arise. At the outset of this relationship, it is agreed to that civil legal actions will not be taken against the patient by the doctor nor will legal action be taken by the patient against the doctor, staff, or office. Neither patient nor physician will work with law enforcement, insurance company, licensing boards, district attorneys, employers, or any other entity against the other in criminal or civil matters, except in cases where direct threat or harm is generated by one against the other (e.g. intentional battery, vandalism, breaking & entering, or harassment). For all billing issues, disputed claims, disagreements of approach, questions of negligence, practice concerns, failures to pay, and other civil actions, arbitration will be entered into and payment to the arbitrator will be the responsibility of the party that does not materially prevail or will be divided proportionally as determined by said arbitrator.

Termination of the Agreement and Treatment Relationship

With the exception of the previous section or the material related to confidentiality, this agreement may be terminated by either the physician or the patient. The patient may terminate the agreement (with any exceptions of any items explicitly listed in the previous sections) at any time voluntarily. The physician may terminate if the patient fails to fulfill the agreed to stipulations (e.g. failure to pay in a timely manner despite reasonable efforts made to collect, failure to use medication as prescribed or agreed to, failure to make and keep appointments in a consistent manner, repeatedly placing himself or herself in danger). Additionally, if the physician believes that he is unable to provide safe and/or effective care for the patient because of such things as associated medical problems, intensity of services required, resolution of the problem for which treatment was initially sought, moving to another city, or reaching an age that would better be served by another specialist, the physician may terminate this agreement and will provide appropriate referrals to other, potentially suitable, providers.

Initial This Line to Represent Understanding & Acceptance of this Page: _____

I confirm I have read, agree with in full, and will comply by the foregoing 4 pages of the Treatment Contract. I understand that both physician & patient have bargaining power and that this is not a contract of adhesion. I have rights, alternatives, and am under no coercion or duress. I agree with good conscience, and the agreement is neither harsh nor one-sided.

(Patient Signature)	(Date)	(Dr. Stone Signature)	(Date)

HIPAA Notice of Privacy Practices Statement: Notice of Information Practices and Privacy Statement:

Windows Of Opportunity, Inc, Charles F. Stone, D.O.
Laguna Hills, Santa Ana, South Lake Tahoe, & Gardena, California
Contact: 23046 Carlota, Suite 600, Laguna Hills, CA 92653
Phone: 949-939-6302 or 888-742-7014

How We Collect Information About You: Windows of Opportunity, Inc & Charles F. Stone, D.O. and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between the office, but still protected as private and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance, If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page that simply records the number of visitors and no other data.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of the office, but still protected as private. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

When you sign a request for health coverage, your health plan is allowed to collect PHI. PHI includes both medical and ID information. Examples of PHI are your diagnosis, social security number, birth date, and phone number. Your health plan may use and share PHI for the following reasons: To make a referral, To provide treatment, To coordinate care, To pay provider claims, To comply with a legal requirement, To investigate a quality concern, To protect personal safety, or in the cases of imminent foreseen dangerousness. Written approval is required for any other release of PHI. If you cannot provide written approval, you may choose a legal representative to act for you. Your PHI in not shared with your employer or family members unless you give written authorization and if it is in your best medical and emotional interests. If you have concerns about how your PHI was used or shared you may contact us. Your concerns will be investigated. We will gladly discuss with you any and all concerns and together reach conclusions about appropriate remedies and notifications. According to the regulations, you may inspect your health records kept since April 2003. You have the right to see how your PHI was used and shared.

As described elsewhere in our treatment agreement, communication within the office is not recorded by electronic means, may not be recorded by electronic means, and is the most appropriate and certain way to assure confidentiality in communication about your issues, diagnostic test results, health, well-being, and treatment plan. Communication by phone, email, Skype (or other secured video interaction), text messaging, or other method outside of face-to-face contact in the office, while permissible, is not ideal and may be subject to breaches in privacy and confidentiality. Our office doctors and staff will be diligent to not share protected and personal information by any means that you as the patient have not confirmed to be acceptable and appropriate for your particular situation.

I have received a copy of this PHI information statement and have had any immediate questions answered.

Patient or Guardian:_____ Date_____

Patient Name: _____ Date of Incorporation: _____

Incomplete Sentences

These are the only directions you will receive: Please complete at least seven of the following sentences. You may complete all sentences if you wish. If you need more space, you may use the back of this page or another page.

1. A best friend _____
2. Mother _____
3. My worse childhood experience was _____
4. I am happiest when _____
5. I am _____
6. Why _____
7. When I am alone with my thoughts I _____
8. My favorite day of the week is _____
9. If I could change one thing about _____, I would _____
10. My heart _____
11. I describe my life as _____
12. I enjoy sex most _____
13. I find myself _____
14. A father _____
15. The best memory _____
16. I wonder _____
17. I dream _____
18. My closest support _____
19. Mothers _____
20 Luck _____
21 A secret wish that I keep is _____
22. My biggest fear is _____
23 My body is _____
24 Spiritually, I feel _____
25 No one understands _____
26 The hardest thing about my life is _____

THE FAMILY PORTRAIT:

These will be the only directions you receive. Please draw a picture of those people or things that you describe as family. Please include facial expressions of people. If an animal or a place is important, please don't forget to include it. This drawing can be pleasant or unpleasant. It can be representative of what you grew up with or of what you have now. It can be a full page of smiling faces, it can be an empty page, it can be what you want it to be and it can represent what you want it to represent. It can be what you fantasize about or what your reality is. You may use as many or as few sheets of paper as you choose. Please write your name and the date on each piece of paper that you use.

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Formedic

PAGE # CHART #

NAME	MARITAL STATUS S M W D SEP	DATE OF BIRTH	DATE
STREET ADDRESS		CITY STATE, ZIP	
PHONE # - HOME ( )	WORK # ( )	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE # ( )
IF UNDER 18 **PARENT / GUARDIAN**			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE # ( )	ADDRESS	RELATION
S.S. #	DRIVER'S LICENSE #	REFERRED BY	

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)			RELATIONSHIP
BILLING ADDRESS			PHONE # ( )

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#	BENEFIT CODE
			I.D.#
2) INSURANCE COMPANY	ADDRESS		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP#	BENEFIT CODE
			I.D.#
MEDICARE I.D.#		MEDICAID I.D.#	
OTHER COVERAGE			

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. _____ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE — MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT NAME *(please print)* ..... DATE .....

PARENT / GUARDIAN *(please print)* ..... SIGNATURE .....

HIPAA COMPLIANT

PREF® FORMEDIC® 2002D 12D WORLDS FAIR DR. SOMERSET NJ 08873

HEALTH QUESTIONNAIRE

Formedic

REASON FOR VISIT

FAMILY HISTORY — *IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE*

1) Epilepsy	6) Thyroid	11) Osteoporosis	16) High cholesterol
2) Migraine	7) Hayfever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) Hypertension	20)

HOSPITAL ADMISSIONS *not including pregnancies*

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING - *INCLUDE THOSE YOU BUY WITHOUT A PRESCRIPTION*

ALLERGIES

VACCINE — YEAR OF LAST

- Tetanus / Td
- Influenza (flu)
- Pneumonia
- Hepatitis

TEST / EXAM — YEAR OF LAST

- Rectal/Stool
- Cholesterol
- Eye exam
- TB test
- Hepatitis

MEDICAL HISTORY — *MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.*

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - *frequent*
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Failing vision ☐ Eye pain
- ☐ Double or blurred vision
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath:
  - ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain - *when walking*
- ☐ Varicose veins / Phlebitis
- ☐ Cold numb feet
- ☐ Loss of appetite - *recent*
- ☐ Difficulty swallowing
- ☐ Heartburn ☐ Peptic ulcer
- ☐ *Persistent* nausea / Vomiting
- ☐ Abdominal pain- *chronic*
- ☐ Gallbladder trouble
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Inflammatory Bowel Syndrome
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- Urination - Overactive Bladder
  - ☐ Overnight more than twice
  - ☐ More than 8 times / 24 hrs.
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence — urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections - *frequent*
- ☐ Sexually transmitted diseases
- ☐ Sexual problems
- ☐ Weight loss ☐ Gain — *recent*
- ☐ Anemia ☐ Bruise easily
- ☐ Blood transfusions
- ☐ Cancer ☐ Chronic fatigue
- ☐ Diabetes ☐ Thyroid disease
- ☐ Seizures ☐ Stroke
- ☐ Tremor / hands shaking
- ☐ Numbness / tingling sensations
- ☐ Headaches — *frequent*
- ☐ Arthritis / Rheumatism
- ☐ Back pain - *recurrent*
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis
- ☐ Foot pain ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Any type of sleeping difficulty
- ☐ Depression ☐ Nervousness
- ☐ Agitation ☐ Memory loss
- ☐ Moodiness ☐ Suicidal thoughts
- ☐ Phobias ☐ Mental illness
- ☐ Feelings of worthlessness
- ☐ Rheumatic Fever ☐ Scarlet Fever
- ☐ Chickenpox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German measles
- ☐ Tuberculosis ☐ Herpes
- ☐ AIDS / HIV
- ☐ Alcohol _____ oz. per week
- ☐ Coffee / Tea _____ cups per day
- ☐ Smoking - cig/day ____ # years ____ year quit ____
- ☐ Exercise _____
- ☐ Street drugs _____
- ☐ Acupuncture / tattoos

Hair loss: ☐ progressive ☐ recent

MALES - ☐ Prostate problems

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of flow____ Length of cycle____

Date — 1st day of last period _____

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies ____ Abortions ____

Miscarriages ____ Live births ____

Birth control method _____

B.C. pill (name) _____

☐ Flushing / Menopause

Date of last Pap test _____

☐ Normal ☐ Abnormal

Date of last mammogram _____

☐ Normal ☐ Abnormal

NOTES

LITHO IN CANADA

For Minors, Dependents, and Other Patients Not Responsible for their own Payments

*Parents please note that confidentiality is still protected between the doctor and the patient. It is not held between the doctor and the person financially responsible for payment.

Patient's Name: _____

Legal Parent or Conservator: _____

Relationship to Patient: _____

Person Responsible for Payment if Different: _____

Mailing Address: _____

Contact Telephone Number: _____

Contact Email Address: _____

Declaration by Parent, Legal Guardian, or Conservator:

I _____ authorize Dr. C.F. "Chip" Stone, to provide medically appropriate treatment for _____. My relationship to this person is _____.

I request that information sharing be restricted to the locations, people, and places as I have addressed them on the appropriate form found elsewhere in this material. I have reviewed the packet of information and the information provided has been completed.

_____ Signature of Legal Guardian, Parent, or Conservator

_____ Signature of Patient

_____ Today's Date.

Charles "Chip" Stone, D.O. **[CA License 20A7997]**
Windows Of Opportunity, Inc
GENERAL CLINICAL & FORENSIC PSYCHIATRY
Laguna Hills, California

TREATMENT (& MEDICATION) CONSENT FORM

While everything in life has risks, the anticipated benefits will ALWAYS outweigh the anticipated risks.

Prior to beginning any and all treatment (medication or therapy or other non-drug treatments), I, _____ will have been sufficiently and satisfactorily advised (verbally, with written material, and/or direction to websites or medical information) of the potential risks, potential benefits, and potential limitations of the medication (or other treatment) I have been prescribed by Dr. Stone. I'm aware of both FDA and "off label" uses of medication. I also understand that there are alternatives to the proposed treatment, have been informed of what alternatives are available (including the absence of medication treatment or addressing my issues with therapy alone or with the assistance of other medical professionals in other disciplines). I have sufficient information about these alternatives to allow me to make a competent informed decision.

I have been advised of the general side effects that are not uncommon with any medication (such as dizziness or upset stomach) as well as the less frequent, but more dangerous risks such as allergic reaction, choking, suicidal thinking, organ failure, and even death. I am aware of the potential for some medications (such as stimulants) to increase my risk of cardiac death and aware of other medications (such as mood stabilizing medication) which may increase my chance of Diabetes, elevated cholesterol, or weight gain. I will have disclosed my medical information to Dr. Stone and made him aware of any and all known medical conditions I have or that I am aware of that run in my family. Specifically regarding anti-depressant medication, I am aware that there are risks of such things as recklessness, racing thoughts, impulsivity and other examples of mania; I am aware that people up to age 24 have been shown to have a higher incidence of suicidal behavior and/or thinking when using certain anti-depressant medication. And, risks such as bleeding, pancreatitis, severe rashes, bone weakening, kidney disease, tremors, seizures, meningitis, or other conditions will be discussed to my satisfaction prior to the onset of treatment.

I understand that the use of medication is voluntary and, unless I am under a court order or have a conservator that tells me I must use the medication, I am under no obligation to use this medication. Thus, I may stop using this treatment at any time and for any reason. I will have been advised of the risks of stopping medication abruptly and both the potential physical effects, such as withdrawal symptoms, and psychological effects, such as a worsening of depression, mood swings, sleep problems, or anxiety of abruptly stopping.

At this point, the intensity of my distress and how that distress impacts my daily functioning is sufficiently severe such that I choose to use the prescribed and/or recommended medication. I understand that there are risks involved and that my doctor will attempt to monitor me closely for the emergence or presentation of any of those risks. Together, Dr. Stone and I will make treatment decisions based upon the severity, intrusiveness, and intensity of my symptoms weighted against the presence or risk of emerging adverse effects. I know that my response to treatment will take time and that the benefits are expected to far outweigh any risk.

I hold Dr. Charles F. "Chip" Stone legally, professionally, ethically, and morally blameless for any and all adverse effects that emerge and acknowledge that I have had a disclosure of potential adverse effects that satisfies my curiosities and concerns. Dr. Stone agrees that he will encourage me to fully confide and be upfront about the emergence of any potentially hazardous adverse effects, thinking, or behavior. Dr. Stone will order monitoring blood tests, follow up visits with me to reduce the chance of adverse effects occurring. I agree to follow recommendations or assume responsibility for any negative outcomes. I acknowledge that, as a reasonable person, I have the education needed to proceed with my decisions.

_____	_____	_____
Patient (or Rep) Signature	Printed Name	Date

AUTHORIZATION TO RELEASE INFORMATION & RECORDS AND REQUEST FOR COLLABORATIVE AND COORDINATION OF CARE:

If there are other providers that you would like to have share information with Dr. Stone, please complete the form below and submit it directly to the other provider. Material that you may wish to have shared include recent laboratory tests, X-ray results, MRI results, EKG results, medication lists, information from previous psychiatrists, information from schools, or information from your family doctor.

However, you are under no obligation to request the sharing of your information. The information is generally able to be provided directly from you to Dr. Stone and thus, Dr. Stone does not routinely seek other information that you are able to provide directly. Therefore, you do not need to feel an obligation to request or share this information. This form is only to serve as a convenient way for you to request the information if you would like to.

FROM PATIENT: _____ DOB: _____

Dear Doctor _____: Today's Date: _____

I have recently begun treatment with Dr. Charles "Chip" Stone. His secured fax line is 888-742-7014 and I would request from you either a brief summary of my treatment with you or a few progress notes that contain information about my treatment. Faxing is a safe and secure way to submit 10 pages or less of this information to Dr. Stone. For more than 10 pages, copies may be mailed to Dr. Stone at the following address:

23046 Carlota, Suite 600; Laguna Hills, CA 92653

In addition, if you have anything specific that you would like Dr. Stone to address in my treatment with him, please place that information in your letter as well. To reach Dr. Stone by phone, you may contact him at 949-939-6302.

I appreciate your time and attention to this matter as well as the care that you have provided me. Thank you in advance for sending a brief summary to Dr. Stone so that my health can improve.

_____	_____	_____	_____
Printed name	Signature	Date	Phone #