16450 Los Gatos Blvd., Ste 112
Los Gatos, CA 95032
Tel. (408) 402-0450 | Fax (408) 402-0950

Child Registration Form

Patient Information

(Fields in RED are Required)

Today's Date: ____________

Patient Last Name: __________________________ First Name: _________________________ MI: _____

Date of Birth: ____________ Age: ________ Gender: _____ Social Security No. _____________________

Address: ___________________________________ City: __________ State: ____ Zip Code: ________

Primary Contact No.: _________________________ Email: __________________________________

School Attended: ____________________________ Grade: __________

Referred by: ________________________________

** **ALLERGIES to Medications** ** (please list all): ____
____

Parent/Legal Guardian Contact Information

Name of Parent/Legal Guardian: ____________________________ Relationship to Patient: _____________

Home Address: ____ Home Phone No.: _________________

Work Phone No.:____________________________ Cell Phone No.: _______________________________

Medical Contact Information

Pediatrician Name: ______________________________________

Pediatrician Address:____

Pediatrician Phone No.: ________________ *Permission to Contact Pediatrician (please check one):* ___ Yes ___ No

Primary Therapist Name: ___________________________________

Therapist Address:____

Therapist Phone No.: ____________________ *Permission to Contact Therapist (please check one):* ___ Yes ___ No

Emergency Contact Information

Emergency Contact Name: _______________________________ Contact Phone No.: ________________

Relationship to Patient: ___________________________________

Family Demographics

______________________________ ______________________________

Name of person completing form Relationship to patient

Parents:

______________________________ ______________________________

Mother's Name Mother's Occupation

Age: __________ Highest level of education complete: ______________________________

*Any learning problems, attention problems, or behavior problems:

____

*Any medical problems:

____

______________________________ ______________________________

Father's Name Father's Occupation

Age: __________ Highest level of education complete: ______________________________

*Any learning problems, attention problems, or behavior problems:

____

*Any medical problems:

____

Please describe current living arrangements. Be sure to include blended family members, whom the child lives with, custody arrangements, etc. If this is a blended family, please provide stepparent demographics.

____

____

____

____

Siblings:

	Name	Age	Living at home? If not, where?	Medical, social, school problems
1.				
2.				
3.				
4.				

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Developmental History

1. How was your health during pregnancy? ______________________________
2. How old were you when your child was born? __________ 3. Was (s)he born on schedule? ______________
4. Do you recall using any of the following substances or medications during your pregnancy?

Substance	Never	1-2 times	3-9 times	10-19 times	20-40 times	40+ times
Beer or Wine						
Hard Liquor						
Coffee/Cokes/Caffeine						
Cigarettes						
Street Drugs (If yes, list)						

5. During pregnancy, did you ingest Valium, tranquilizers, antiseizure medications, antibiotics, sleeping pills, or other prescription medications? ☐ Yes ☐ No *If yes, please list below:

List: ______________________________

6. Did you have toxemia or eclampsia? ☐ Yes ☐ No
7. Was there Rh factor incompatibility? ☐ Yes ☐ No
8. Were there indications of fetal distress during labor or birth? ☐ Yes ☐ No
9. What was the duration of labor? ______________________________
10. What was the child's birth weight? __________
11. Were there health complications following birth? ☐ Yes ☐ No Explain: ______________________
12. Were there early infancy feeding problems? ☐ Yes ☐ No
13. Was the child colicky? ☐ Yes ☐ No
14. Were there early infancy sleep pattern difficulties? ☐ Yes ☐ No
15. Problems with being alert? ☐ Yes ☐ No
16. Did the child have any congenital problems? ☐ Yes ☐ No
17. Was the child an easy baby? ☐ Yes ☐ No
18. Did the child enjoy cuddling? ☐ Yes ☐ No
19. When (s)he wanted something, how insistent was (s)he? ______________________________
20. How would you rate the activity level of the child as a toddler?

    ☐ Very active ☐ Active ☐ Average ☐ Less active ☐ Not active
21. Developmental Milestones. Please note the age ranges for each of the following behaviors:

BEHAVIOR	3-6mos	7-12mos	13-18mos	19-24mos	25-36mos	37-48mos
Sit up						
Crawl						
Walk						
Speak single words						
Speak in sentences						
Toilet trained for bladder						
Toilet trained for bowel						

22. Approximately how much time did toilet training take from onset to completion? ______________________
23. How well did you child deal with transition and change?

____

____

Medical History

Please rate each of the medical conditions below:

CONDITION:	Very Good	Good	Fair	Poor	Very Poor
Health					
Hearing					
Vision					
Gross Motor Coordination					
Fine Motor Coordination					
Speech Articulation					

*If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

1. Has (s)he had any chronic health problems (i.e. asthma, diabetes, heart condition)?

____

____

2. Operations: ___________________________________
3. Hospitalization for illness:

____

____

4. Head injuries: ___________________________________
5. Convulsions with or without fever: ___________________________
6. Coma: _____________________ 7. Poisoning: ___________________
8. Persistent high fevers: ___________________________
9. Loss of consciousness: ___________________________
10. Is there any suspicion of alcohol or drug use? ___________________
11. Is there a history of physical or sexual abuse? ___________________
12. Sleep:
    A. Does your child settle down to sleep? ___________________
    B. Sleep through the night without disruption? ___________________
    C. Experience nightmares, night terrors, sleep walking, sleep talking? ___________
    D. Is your child a very restless sleeper? ___________________
13. Does your child have bladder control problems? ___________________
14. Does your child have bowel control problems? ___________________
15. Does your child have appetite control problems? ___________________
16. When was your child's last physical examination? ___________________
17. List all medications your child has taken and/or is taking for non-psychological problems:

____

____

Social History

Siblings:

1. How does your child get along with his brothers and sisters? ______________________________

____

Peers:

2. Does your child seek friendships with peers? ______________________________
3. Is your child sought by peers for friendship? ______________________________
4. Does your child play primarily with children their own age? Younger? Older? ______________________________

____

5. Describe any problems your child may have with peers: ______________________________

____

____

Parents:

6. Check any of the following strategies that have been successful in addressing behavior:

☐ Verbal reprimands ☐ Time Out ☐ Removal of privileges ☐ Rewards

☐ Acquiescence to child ☐ Avoidance of child

7. On the average, what percentage of the time does your child comply with initial commands:

☐ 0-20% ☐ 20-40% ☐ 40-60% ☐60-80% ☐80-100%

8. On the average, what percentage of the time does your child eventually comply with commands:

☐ 0-20% ☐ 20-40% ☐ 40-60% ☐60-80% ☐80-100%

9. To what extent are you and your spouse consistent with respect to disciplinary strategies?

☐ Most of the time ☐ Some of the time ☐ None of the time

Self:

10. What are your child's main interests and hobbies? ______________________________

____

11. What are some of your child's greatest accomplishments? ______________________________

____

____

12. What do you like about your child? ______________________________

____

____

____

School History

1. Please summarize your child's progress (academic, social, testing) within each of the grade levels below:

Preschool: ____

____

Kindergarten: ____

____

Grades 1-3: ____

____

____

Grades 4-6: ____

____

____

Grades 7-9: ____

____

____

Grades 10-12: ____

____

____

2. Has your child ever been in any type of special educational program? Explain. ____________________

____

3. Has your child ever been suspended or expelled from school for reasons of behavior? ______________

____

4. Does your child like school? ____

5. Do teachers like your child or have any problems concerning your child? ______________________

____

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Treatment History

1. Has your child ever has any of the following forms of treatment?

Type of Treatment	Dates	Duration	Key Personnel
Individual Psychotherapy			
Group Psychotherapy			
Family Therapy			
Hospitalization			
Residential Treatment Ctr.			
Therapeutic Board School			

2. Has your child ever been prescribed any of the following?

Medication	Dates	Duration	Key Personnel
Ritalin			
Cylert			
Dexedrine			
Prozac / Zoloft			
Other antidepressants			
Anticonvulsants			
Antipsychotics			

3. List the names of any and all mental health professionals who have provided treatment. Please include pediatrician or primary care physician.

Name: ____ Degree: ____________________
Address: ____
Telephone: ____ Type of Practice: ___________________________

Name: ____ Degree: ____________________
Address: ____
Telephone: ____ Type of Practice: ___________________________

Name: ____ Degree: ____________________
Address: ____
Telephone: ____ Type of Practice: ___________________________

Behavior Check Lists

1. Problems with concentration (check all that apply)

☐ Fidgets ☐ Difficulty remaining seated ☐ Easily distracted

☐ Difficulty waiting his/her turn ☐ Often blurts our answers to questions ☐ Difficulty playing quietly

☐ Difficulty following instructions ☐ Difficulty sustaining attention from one activity to another

☐ Often talks too much or interrupts ☐ Often does not listen

☐ Often engages in physically dangerous activities.

*At what age did these problems begin? ______________________________

2. Problems with authority (check all that apply)

☐ Often loses temper ☐ Often argues with adults ☐ Is often angry or resentful

☐ Often actively defies or refuses adult requests or rules ☐ Is often spiteful or vindictive

☐ Often deliberately does things that annoy other people ☐ Often blames others for his own mistakes

☐ Is often touchy or easily annoyed by others ☐ Often swears or uses obscene language

*At what age did these problems begin? ______________________________

3. Problems with rules (check all that apply)

☐ Stolen something without confronting anyone ☐ Run away from home, at least twice

☐ Lies often ☐ Has deliberately set fires ☐ Often truant ☐ Has engaged in breaking and entering

☐ Forced someone into sexual activity ☐ Used a weapon in a fight ☐ Often initiates physical fights

☐ Stolen something when it involved confrontation ☐ Physically cruel to people

*At what age did these problems begin? ______________________________

4. Problems being alone (check all that apply)

☐ Shows unrealistic and persistent worry about possible harm to parental figures

☐ Shows unrealistic and persistent worry that a terrible event will separate him/her from his/her parental figures

☐ Persistent refusal to go to school ☐ Persistent refusal to sleep alone

☐ Persistent avoidance to being alone ☐ Repeated nightmares about being separated

☐ Frequent complaints of feeling sick ☐ Excessive distress in anticipation of being separated from parental figures

☐ Excessive distress when separated from home or parent figures

*At what age did these problems begin? ______________________________

5. Problems with anxiety (check all that apply)

☐ Unrealistic worry about future events ☐ Unrealistic concern about competence

☐ Unrealistic concern about appropriateness of past behavior ☐ Marked self-consciousness

☐ Marked inability to relax ☐ Excessive need for reassurance ☐ Frequent complaints of feeling sick

*At what age did these problems begin? ______________________________

6. Problems with depression (check all that apply)

☐ Depressed mood most of the time ☐ Irritable most of the time ☐ Loss of pleasure in normal activities

☐ Decrease/increase in appetite ☐ Weight loss ☐ Sleeps most of the time

☐ Trouble sleeping ☐ Fatigue or loss of energy ☐ Acts either groggy or agitated

☐ Feelings of worthlessness or excessive guilt ☐ Diminished ability to concentrate

☐ Suicidal thoughts or attempts

*At what age did these problems begin? ____________________________

7. Additional problems (check all that apply)

☐ Cuts or burns oneself ☐ Reckless sexual activity ☐ Overreact to being touched

☐ Compulsive rituals ☐ Interested in the occult or Satan ☐ Panic attacks

☐ Explosive temper out of all proportion to triggering event ☐ Unusual fears ☐ Pattern of reckless driving

☐ Pattern of intense and unstable relationships ☐ Extremely dependent or needy

☐ Pattern of reckless spending ☐ Gambles

Family History

Please use the space below and on the last page to document any family history (blood relatives) of mental illnesses, depression, school problems, substance abuse and alcohol problems, psychiatric treatment, suicides, or behavior problems. Please include at least one generation removed.

____

____

____

____

____

During the past four weeks, how often has your child:

	Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**
Had trouble concentrating	0	1	2	3	4
Hurt or torture animals	0	1	2	3	4
Been taken advantage of by others	0	1	2	3	4
Set or threaten to set a fire	0	1	2	3	4
Pulled out his/her hair	0	1	2	3	4
Had hallucinations (report hearing, seeing, etc., things that were not there)	0	1	2	3	4
Gotten startled or acted jumpy	0	1	2	3	4

Failed to complete activities or assignments	0	1	2	3	4
Gotten overly upset if he/she made a mistake	0	1	2	3	4

1. Please state as clearly as possible the problems, which concern you, regarding your child:

2. Additional comments and notes:

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Name: ______________________________ Date: ____________

Completed by: _______________________

Please check all that apply:

General
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble sleeping

Skin
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair and nail changes

Head
- ☐ Headache
- ☐ Head injury
- ☐ Neck pain

Ears
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

Eyes
- ☐ Vision loss/changes
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts

Nose
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus pain

Throat
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

Neck
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Breasts
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

Respiratory
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

☐ **Cardiovascular**
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing lying down
- ☐ Swelling
- ☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

Urinary
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength

Vascular
- ☐ Calf pain with walking
- ☐ Leg cramping

Musculoskeletal
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Hematologic
- ☐ Ease of bruising
- ☐ Ease of bleeding

Endocrine
- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

Psychiatric
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss

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Authorization for Use or Disclosure of Patient Treatment Information, Medical, Psychiatric, and Drug/Alcohol Information

I Hereby Authorize:

Wendla A. Schwartz, MD, Mark A. Ritchie, MD, of Solutions Psychiatric Associates or any Staff Member/Employee/Contract Clinical Staff Member of Solutions Psychiatric Associates

16450 Los Gatos Blvd., Ste 112, Los Gatos, CA 95032

Address City State Zip

To Release To:

Wendla A. Schwartz, MD, Mark A. Ritchie, MD, of Solutions Psychiatric Associates or any Staff Member/Employee/Contract Clinical Staff Member of Solutions Psychiatric Associates

16450 Los Gatos Blvd., Ste 112, Los Gatos, CA 95032

Address City State Zip

Medical Records and Information Pertaining to:

Name of Patient (List other names used as well)

Address City State Zip Telephone Number

The medical records and information shall include all information provided by the undersigned to Wendla A. Schwartz, MD, Mark A. Ritchie, MD, and/or any staff member, employee, or contract clinical staff member of Solutions Psychiatric Associates, all of which may be shared among Wendla A. Schwartz, MD, Mark A. Ritchie, MD, and/or any staff member, employee, or contract clinical staff member of Solutions Psychiatric Associates as is reasonably necessary to provide medical treatment.

Duration: This authorization shall remain in effect until revoked in writing by the undersigned. The authorization may be revoked in writing by the undersigned at any time.

Restrictions: I understand that, except as provided above, no recipient of any medical records or information may use or disclose the medical information unless another authorization is obtained from me or such use is required in an emergency.

Purpose: Any authorized recipient of medical records and information may use the medical records and information only for providing the medical/psychiatric evaluation, diagnosis and treatment. No information will be disclosed to parties outside the clinic except as provided above.

Printed Name Signature Date

If signed by other than patient, please indicate relationship: ______________________________

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Fax (408) 402-0950

How to Reach Your Doctor After Hours in an Emergency

Dr. Mark A. Ritchie: mritchiemd@gmail.com
Dr. Wendla A. Shwartz: drschwartz@solutionspsych.com

Dear Patients of Solutions Psychiatric Associates,

Front Desk Operating Hours:
Monday thru Friday 10:00 AM to 5:00 PM
Closed on Tuesdays

For all issues during those hours we urge you to contact our front desk at:
(408) 402-0450 or email admin@solutionspsych.com

For urgent issues that cannot wait until business hours, you may contact your physician at the emails above. Please do not use the mail service for routine prescription refills as your doctor does not have access to your chart when out of the office.

DO NOT USE THE EMAIL SERVICE FOR EMERGENCY OR LIFE THREATENING EVENTS AS THE DOCTOR MAY NOT RESPOND TO YOUR EMAIL RIGHT AWAY. FOR ALL LIFE THREATENING ISSUES, DIAL 911.

Billing for emails: Regardless of the time entailed, a 15-minute minimum will always apply and a $125 charge will be incurred for after hour emails. After that, charges will accrue at the physician's regular rate in six-minute minimum increments. **Fees will be charged directly to the credit card you have on file with our office and billing statements will be provided to you at the end of the month.**

Occasionally, you will need to transmit large amounts of information or material via email to your doctor or you may ask your doctor to transmit information or answer questions that are too detailed to be handled via administrative staff. Often times, it is more efficient and less expensive to use email than to schedule a telephone or in-office appointment. In these cases, please also use the email service. Rates will apply as above.

My signature below indicates that I understand and agree with the above policies. I also understand that email is not a completely secure means of data transmission and I accept the risks to my privacy that may occur as a result of contacting my doctor via email.

______________________	______________________	________
Patient Name	Patient Signature	Date

If Patient is a Minor or if Patient is not the financially responsible party,

______________________	______________________	________
Name of Financially Responsible	Signature of Financially Responsible	Date

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Acknowledgement of Email Communication

I acknowledge that email is not a secure form of medical record transfer but wish to communicate with Solutions Psychiatric Associates with the following email:

(Please print)

Email Address: ____ _ Date: ________________

Owner of Email (if not patient): ______________________ Relationship to Patient: ____________________

Patient Name: _______________________ Patient Signature: ______________________________

Email Authorization for Billing Purposes

I understand that invoices and receipts contain my personal medical information but authorize Solutions Psychiatric Associates to send all of my invoices and receipts to the following email:

(Please print)

Email Address: ____ __ Date: ________________

Owner of Email: _______________________ Relationship to Patient: ________________________

Patient Signature: _______________________________________

Please note that our office can only communicate with the emails that are listed above.
To update or change email information, please visit our office to fill out another form.
For verification purposes, we cannot update your email addresses by phone, email or fax.

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Consent to Treatment

Welcome to Solutions Psychiatric Associates, a Medical Corporation. We offer counseling, assessment and psychiatric services for children, adolescents, families and adults. These services are provided through individual, family, couples and group treatment formats. We want you to be sure that you understand the nature of the services that you are receiving and need you to read the information below and to sign and date this form. Please note that if you are signing for a minor child then all statements within this document apply to that minor child.

I, ______________________________, hereby request for myself, or my minor child, __________________________, to receive psychiatric and/or psychological care and treatment voluntarily from Solutions Psychiatric Associates, a Medical Corporation. I understand that such care and treatment may consist of an evaluation process, counseling, and case management.

Solution Psychiatric Associates is hereby authorized to provide the treatment/services described above if this request is accepted. Such consent, however, does not waive my civil rights; I reserve the right to decline treatment against the advice of my clinician(s) at any time. I also have the right to request a change of clinician(s) without being subjected to discrimination or any penalty.

I further understand that my records are considered pursuant to W & I 5328 and will not be released to outside individuals or agencies without my expressed written consent. However, I realize that certain information may be released without my authorization under specific circumstances including, but not limited to, the following:

1. Suspected child physical and/or emotional abuse and dependent adult or elder abuse must be reported to the authorities immediately. This may include sexual contact between an adult and a child.
2. If a client implies a serious threat of violence or danger to a person or his/her property, the clinician is bound by duty to forewarn that person and to notify the authorities (police).
3. A therapist may provide reasonable protective care to a suicidal client, under certain circumstances.
4. Counseling records may be subpoenaed by court of law, under certain specific circumstances.
5. A release of information is signed by the client to authorize the counselor to obtain and exchange information with outside individuals/agencies relevant to treatment.
6. Within our organization, we work as a team. Thus, one professional staff member may periodically consult with other qualified professional staff members to ensure that we are delivering the highest quality services to our clients. All of our staff is bound by the same requirement for confidentiality.

I also understand that I may address any concerns or grievances with the staff at Solutions Psychiatric Associates or any representative of my health insurance company at any time. I understand that I may also contact the licensing board which regulates my doctor's professional practice. I am freely choosing to enter into treatment, and I understand that I may discontinue my treatment at any time. If I choose to continue treatment to Solutions Psychiatric Associates I acknowledge that I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives if they are available.

I have been informed that my clinician(s) is/are:

- ☐ A licensed clinician
- ☐ A clinician working toward licensure under the supervision of the following:
  licensed psychiatrist/psychologist: ______________________________ License No. __________________
- ☒ A licensed psychiatrist: Mark A. Ritchie, MD License No. A48077
- ☒ A licensed psychiatrist: Wendla A. Schwartz, MD License No. G072445

☐ I am authorized to consent to treatment. I have read the above and I agree to accept treatment for myself/my child, and I further agree to all conditions set forth herein.

______________________	______________________	__________
Printed Name	Client/Parent or Guardian Signature	Date
______________________	______________________	__________
Printed Name	Witness/Clinician Signature	Date

Solutions Psychiatric Associates
Office Policies

Cancellation/Rescheduling Policy: Please notify the office 7 days prior to your appointment should you wish to cancel/reschedule. Any cancellation or rescheduling done after the 7-day period will be subjected to the full cost of the appointment. The cancellation policy is implemented as courtesy to all our patients because it allows us time to inform other patients of any availability and provides our doctors the appropriate time to coordinate care for other patients in need.

Prior Authorizations for Medications: The demand on doctors' time to complete medication prior authorizations and other insurance work has skyrocketed. For this reason, we are instituting a fee of $270 to complete all such requests. Should the forms require more than a reasonable amount of the doctors' time, you will be notified, and your approval will be obtained before additional work is done and billed.

Prescription Refills: Prescriptions will be written at your regularly scheduled appointments and refills will be provided, when appropriate, without charge through the electronic prescription refill system, or at appointments. All prescriptions provided between appointments, other than those through the electronic system will incur a $60 charge. All telephone and paper prescriptions provided between appointments including those for controlled substances will incur a minimum fee of $60. *Please note that refill requests submitted after 5:00PM or during weekends will not be authorized until the next business day. For this purpose, we ask that patients do not wait until they are completely out of medication to initiate a request. Lastly, for the safety and well-being of our patients, we do not approve any refill requests without a scheduled follow-up appointment.

Invoices: In an effort to be environmentally sensitive, your invoices and statements will be emailed to you by our billing department 5-7 business days after your appointments have taken place. This delay in processing time is needed because the clinical staff and your MD must submit the service and procedures rendered to the billing department.

Billing: Please note that our office requires patients to have a valid credit card on file and we reserve the right to charge the card for any past due balances for missed appointments or services rendered as signed in your financial agreement with us. To avoid a $35 billing fee for unpaid invoices, please pay any past due balances upon receipt.

I have read and understand the stated above and will abide by these policies.

Patient Name	Signature	Date
Name of Financially Responsible Party	Signature	Date

Wendla A. Schwartz, MD
Mark A. Ritchie, MD
16450 Los Gatos Blvd., Ste 112
Los Gatos, CA 95032
Tel. (408) 402-0450
Fax (408) 402-0950

Financial Agreement

Patient Information

Last Name	First Name MI	Home Phone	Cell Phone

Address	City	State	Zip	Email Address

Date of Birth	Gender	Social Security No.	Driver's License No.	Marital Status

Employer	Employers Address	Work Phone

Parent/Guardian or Financially Responsible Party

Last Name	First Name MI	Home Phone	Cell Phone

Address	City	State	Zip	Email Address

Date of Birth	Gender	Social Security No.	Driver's License No.	Marital Status	Relationship to Patient

Employer	Employers Address	Work Phone

CONDITIONS OF TREATMENT AND FINANCIAL AGREEMENT

I hereby certify that the information provided above is correct to the best of my knowledge and in consideration of the named patient.

I hereby consent to and authorize the giving of all treatments, which, in the judgement of the attending physicians at Solutions Psychiatric Associates, Dr. Mark A. Ritchie MD and Dr. Wendla A. Schwartz, MD, may be considered necessary or advisable for the diagnosis, or the treatment of the named patient.

I understand that while the doctor will assist me in obtaining insurance reimbursement by providing me with a properly coded receipt, he will not bill insurance companies directly, nor will he negotiate a settlement on disputed charges. I understand that I am fully responsible for payment of the doctor's charges at the time of services rendered. Failure to comply with this policy may result in postponement or cancellation of future visits. Furthermore, if the amount due is not paid in full, I agree to bear all collection costs, court costs, and legal fees.

I understand that because of the highly specialized nature of this practice, the doctor does not participate in any managed care programs such as health maintenance organization, preferred provider plans, workers' compensation cases or victims witness cases.

I understand that as a courtesy to the physician, if for ANY reason an appointment must be cancelled or rescheduled by the patient, a one week (seven days) notification will be given to the physician's office. Failure to properly notify the physician will result in charges at the usual rate for that appointment. Such charges are not reimbursed by insurance programs.

I understand that the doctor may charge for telephone consultations and for all other uses of his time on my behalf, at the rate of $695 per hour and I have read and understand the above agreement and will abide by these policies.

______________________	______________________	__________
Patient Name	Signature	Date
______________________	______________________	__________
Name of Financially Responsible Party	Signature	Date

16450 Los Gatos Blvd., Suite 112
Los Gatos, CA 95032
Tel. (408) 402-0450
Fax (408) 402-0950

Patient Credit Card Information

Patient Last Name		Patient First Name		
Responsible Party Last Name	Responsible First Name		Responsible Social Security No.	
Credit Card Billing Address		City	State	Zip Code
Type of Card: VISA MASTERCARD AMEX	Credit Card No.		Expiration Date	CVC Code
Name as it Appears on Card				

My signature below indicates that I have read and fully understand the terms and conditions expressed in the **Financial Agreement** provided to me by Solutions Psychiatric Associates. Furthermore, I agree to abide by these policies and I authorized Solutions Psychiatric Associates to apply charges to the credit card information given above for in-office appointments, phone appointments, email correspondences, telephone consultations, emergency services, missed appointments and/or late cancellations. I also understand that Solutions Psychiatric Associates will charge my credit card up to one business day prior to the day for which the services are provided. I may change or terminate this arrangement with written notice to Solutions Psychiatric Associates at any time.

____________________ ____________________ ________

Printed Name Signature Date

Relationship to Patient (if name on card is different from Patient Name): ____________________

Email for Billing Purposes: ______________________________

FOR OFFICE-USE ONLY

☐ Credit Card information was changed/updated over the phone with Solutions Staff.

Staff Name: ____________________ Date: __________ Time: __________