

DAVID TAYLOR, M.D.

2730 WILSHIRE BLVD, SUITE 325
SANTA MONICA, CA 90403
(310) 943-9223

DIPLOMATE OF PSYCHIATRY, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY
DIPLOMATE OF ADDICTION MEDICINE, AMERICAN BOARD OF ADDICTION MEDICINE
DIPLOMATE OF FORENSIC PSYCHIATRY, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

Thank you for scheduling your appointment with Dr. Taylor.

Attached is the new patient paperwork to fill out and bring to your first session. A Release of Information consent form may also be completed if applicable. Contact information and a map to the office are attached as well.

Additional information about Dr. Taylor can be found online: www.DavidTaylorMD.com

I look forward to working together!

Sincerely,

David Taylor, M.D.

Assistant Clinical Professor, UCLA Department of Psychiatry and Biobehavioral Sciences
Diplomate of Psychiatry, American Board of Psychiatry and Neurology
Diplomate of Forensic Psychiatry, American Board of Psychiatry and Neurology
Diplomate of Addiction Medicine, American Board of Addiction Medicine
Qualified Medical Examiner, California Division of Workers Compensation

Demographics

Contact information

Name _____

Birthdate _____

Address _____

Phone numbers (please indicate your preferred number)

Cell _____ OK to leave message?

Home _____ OK to leave message?

Work _____ OK to leave message?

Pharmacy information

Name _____

Phone _____

Emergency contact

Name _____

Relationship _____

Cell _____

Home _____

Work _____

Questionnaire

Background

Today's date _____

Referred by _____

Therapist _____

Primary care physician _____

With whom do you live? _____

Marital status _____

Occupation _____

Questions

- 1) Summarize briefly why you are seeking treatment at this time.

- 2) What symptoms or problems are most concerning?

- 3) When did you first notice the problem? How often does it occur?

4) Are you currently taking any medications (including over-the-counter or herbal supplements)?

5) Do you have any serious or chronic medical conditions (including past surgeries)?

6) Have you had any serious medical accidents, head injuries or seizures?

7) Have you had psychotherapy or psychiatric medications before? Hospitalizations?

8) Do you have any known medication allergies?

9) How much/often do you consume coffee or alcohol? Nicotine? Other substances?

10) Have you ever had any legal problems?

11) Is there a family history of mental illness, substance abuse or suicide?

12) Please indicate if you are/have experienced any of the following symptoms:

<input type="checkbox"/> Headaches	<input type="checkbox"/> Crying often	<input type="checkbox"/> Fears of losing self control
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Unable to enjoy anything	<input type="checkbox"/> Unwanted thoughts
<input type="checkbox"/> Bowel trouble	<input type="checkbox"/> Restlessness	<input type="checkbox"/> Always worried
<input type="checkbox"/> Pain	<input type="checkbox"/> Decreased need for sleep	<input type="checkbox"/> Concentration problems
<input type="checkbox"/> Tremors or tics	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Hearing voices
<input type="checkbox"/> Drug/alcohol cravings	<input type="checkbox"/> Excess energy	<input type="checkbox"/> Seeing things others do not
<input type="checkbox"/> Eating problems	<input type="checkbox"/> Confusion	<input type="checkbox"/> Strange experiences
<input type="checkbox"/> Binge eating	<input type="checkbox"/> Elated/euphoric mood	<input type="checkbox"/> Feel others are against you
<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Excessive spending	<input type="checkbox"/> Constant suspicion/distrust
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Racing thoughts	<input type="checkbox"/> Unusual thoughts
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Irritability	<input type="checkbox"/> Violent behavior
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Impulsive behavior	<input type="checkbox"/> Thoughts to harm others
<input type="checkbox"/> Feeling apart from others	<input type="checkbox"/> Grandiose thoughts/plans	<input type="checkbox"/> Physical abuse
<input type="checkbox"/> Low energy	<input type="checkbox"/> Anger/explosiveness	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Feeling worthless	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Memory problems	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Relationship problems
<input type="checkbox"/> Thoughts of suicide	<input type="checkbox"/> Fears	<input type="checkbox"/> Financial problems
<input type="checkbox"/> Feeling depressed	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Work problems

Office Policies and Consents

Fees

- Payment is due at each session and may be made by cash or check.
- Credit cards are not accepted.

Insurance

- Dr. Taylor does not participate in any insurance panels.
- Some health insurance plans will reimburse a portion of fees paid for out-of-network service.
- Please consult with your insurance carrier in advance.

Canceled Appointments

- If you are unable to keep your appointment, kindly give 48 hours notice to avoid charges.

Missed Appointments

- Missed appointments are charged at the full rate.

Parking

- Underground parking is available for a fee.
- Metered street parking is available nearby.

Arrival

- Inside the waiting room, press the light next to the nameplate for David Taylor, M.D. to indicate your arrival.

Phone Messages

- Voicemail messages left during business hours will be returned promptly.
- Messages left on evenings, weekends and holidays will be returned the following business day.
- In the event of an emergency, proceed go to the nearest emergency room or call 911.

Email Messages

- Email communication is inherently non-confidential. By communicating with Dr. Taylor via email, you are accepting the inherent insecurity and the privacy risks therein.
- Email communication is not to be used for complicated medical matters, urgent issues or emergencies.
- All communication with Dr. Taylor will become part of your medical record.
- Email communication does not constitute legal notice to Dr. Taylor such as where notice is required by contract or any federal, state or local laws, rules or regulations.
- Dr. Taylor does not reply via email, but will gladly respond with a return phone call if requested.

Confidentiality

- The content of sessions is confidential except in certain situations including, but not limited to: cases where a patient may be a danger to self or others; cases of suspected child or elder abuse; cases where a patient may be incapable of taking care of him/herself; certain legal proceedings when required by a judicial subpoena.
- Medical records are separately maintained and are not released without your written authorization.

California Prescription Drug Monitoring Program (PDMP)

- Dr. Taylor routinely uses the State of California Department of Justice Prescription Drug Monitoring Program to access controlled substance prescription history.
- More information about the PDMP can be found online at <https://pmp.doj.ca.gov/pdmp>

Medical Board of California

- Dr. Taylor is licensed and regulated by the Medical Board of California.

Acknowledgement of Independent Practitioner

- Dr. Taylor is an independent practitioner. Although other mental health professionals work in the office suite, Dr. Taylor is not in partnership with them and has no responsibility for their billing. He neither controls nor supervises the services they provide.

Acknowledgement of Receipt for ‘Notice of Privacy Practices’ (HIPAA)

- I acknowledge that I have received (paper or online version) the Notice of Privacy Practices and have been provided an opportunity to review it.



My signature below indicates that I have read the above office policies and consents, and agree to abide by these terms during my professional relationship with Dr. Taylor.

The undersigned patient or responsible party (parent, legal guardian) consents to and authorizes services by David Taylor, M.D. which may include evaluation, psychotherapy, medication therapy and laboratory tests.

The undersigned understands that he/she has the right to:

- Be informed of and participate in the selection of treatment modalities.
- Receive a copy of this consent.
- Withdraw this consent at any time.

Signature _____ Date _____

Name _____

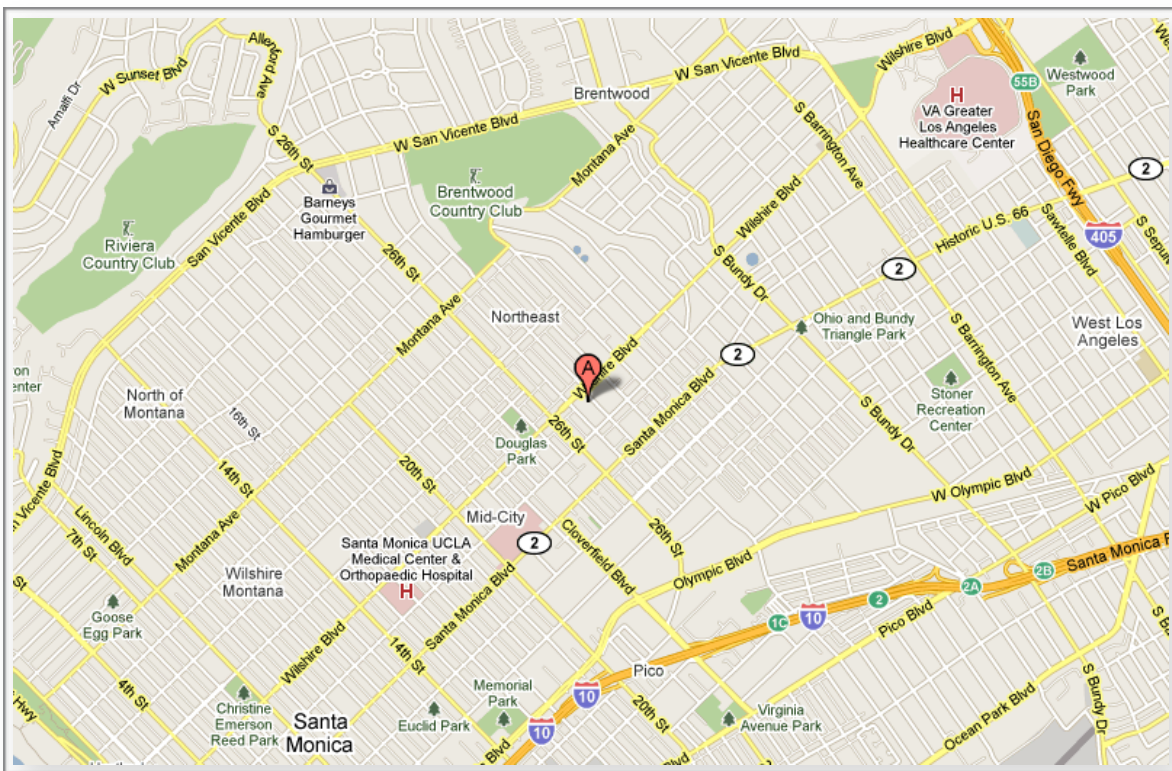
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Santa Monica, CA 90403

(310) 943-9223

(at the corner of Wilshire and Harvard, two blocks east of 26th Street)



Parking is available under the building or on nearby side streets.

www.DavidTaylorMD.com