PRIVATE ACCESS PSYCHIATRY

20054 Crestview Dr., Canyon Country, CA 91351 | 818-731-2100 | Fax: 208-277-3558

Welcome to Private Access Psychiatry

Thank you for choosing Private Access Psychiatry for your mental health care.

YOUR FIRST APPOINTMENT:
Please complete ALL forms in this packet prior to your appointment. This allows us to dedicate your full visit time to understanding your concerns and developing your treatment plan together.

WHAT TO BRING:
- This completed intake packet
- Photo ID and insurance card(s)
- List of current medications including dosages
- Any relevant medical records or previous psychiatric evaluations
- Payment method for copay/coinsurance or self-pay amount

OFFICE POLICIES:
Cancellations: We require 24-hour notice for cancellations. Late cancellations (less than 24 hours) or missed appointments will be charged 50% of the session fee.

Emergencies: If you are experiencing a psychiatric emergency or having thoughts of harming yourself or others, call 911 or go to your nearest emergency room. You may also call or text 988, the Suicide and Crisis Lifeline, 24/7.

Telehealth: We offer secure video appointments for patients located in California. You will receive a link prior to your scheduled telehealth visit.

Insurance & Billing: We are out-of-network with most insurance plans. We provide a superbill for you to submit to your insurance for potential reimbursement. Payment is due at time of service.

We look forward to meeting you.

Sincerely,
Dr. Amy Edwards, DNP, PMHNP-BC
Private Access Psychiatry

Office Hours: Monday - Friday, 9:00 AM - 5:00 PM PST

MINOR NEW PATIENT INTAKE PACKET

Ages 10-17

Please complete ALL forms prior to your appointment

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Included in this packet:

1. New Patient Intake Form - Minor
2. Consent for Treatment - Parent/Guardian Signature Required
3. Minor Consent for Telehealth Services - California
4. HIPAA Notice - Parent/Guardian Acknowledgement
5. Financial Policy and Fee Agreement
6. Credit Card Authorization & Retainer Agreement
7. Emergency Contact Information
8. Medication Informed Consent - Parent/Guardian
9. Authorization for Release of Health Information
10. Columbia Suicide Severity Rating Scale

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New Patient Intake Form - Minor

NEW PATIENT INTAKE FORM
For patients ages 10 and older. For minors, parent/guardian to complete.
Patient Information
Name: _____ DOB: _____ Age: _____
Address: _____
Phone: _____ Email: _____ Preferred Contact: ■ Phone ■ Email ■ Text
Emergency Contact: _____ Relationship: _____ Phone: _____
Parent/Guardian Info (if under 18)
Name: _____ Relationship: _____ Phone: _____
Custody Arrangement (if applicable): _____
Reason for Visit
What concerns bring you here today? _____
_____
Current Symptoms: ■ Depression ■ Anxiety ■ Panic ■ Mood Swings ■ Sleep Issues ■ Anger ■ ADHD/Inattention ■ Trauma ■ Substance Use ■ Suicidal Thoughts ■ Self-Harm ■ Other: _____
Psychiatric & Medical History
Previous psychiatric treatment? ■ Yes ■ No If yes, with whom: _____
Current medications: _____
Medication allergies: _____
Medical conditions: _____
Hospitalizations for mental health? ■ Yes ■ No Details: _____
Family Psychiatric History
Family history of: ■ Depression ■ Bipolar ■ Anxiety ■ ADHD ■ Schizophrenia ■ Substance Use ■ Suicide ■ Other: _____ Which relatives: _____
Substance Use History
Alcohol: ■ Never ■ Past ■ Current Frequency: _____ Last use: _____
Cannabis: ■ Never ■ Past ■ Current Frequency: _____ Last use: _____
Other drugs: _____
Safety Assessment
Current suicidal thoughts? ■ Yes ■ No If yes, describe: _____
Past suicide attempts? ■ Yes ■ No When: _____
Current self-harm? ■ Yes ■ No Methods: _____
Access to firearms? ■ Yes ■ No

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Consent for Treatment - Parent/Guardian Signature Required

CONSENT FOR PSYCHIATRIC TREATMENT

For patients ages 10 and older. For minors under 18, parent/guardian must sign.

I voluntarily consent to psychiatric evaluation and treatment by Private Access Psychiatry. I understand treatment may include diagnostic interviews, medication management, psychotherapy, and coordination with other providers.

Risks/Benefits: I understand benefits may include symptom improvement, but no guarantees are made. Risks may include medication side effects or emotional discomfort during therapy.

Confidentiality: I understand my records are confidential per HIPAA and CA law. Exceptions include danger to self/others, child/elder abuse, or court order. For patients 12+, CA law grants minors certain confidentiality rights.

I agree to participate in treatment planning and to notify the provider of medication changes or side effects.

Patient Name: _____ DOB: _____ Date: _____

Patient Signature (if 12+): _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

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Minor Consent for Telehealth Services - California

MINOR CONSENT FOR TELEHEALTH SERVICES - CALIFORNIA
For patients ages 12-17
Patient Name: _____ DOB: _____ Date: _____
California Minor Consent Laws
Under California law, minors age 12+ may consent to outpatient mental health treatment if:
1. The minor is mature enough to participate intelligently in treatment, AND
2. The minor would present a danger of serious physical/mental harm to self or others without treatment, OR is the alleged victim of incest/child abuse.
Parent/guardian involvement is generally required unless clinically inappropriate. Provider will use professional judgment.
Telehealth Specific Consent
I understand telehealth risks including technical issues and privacy limitations. I agree to be in a private location in California during sessions.
I will provide my physical location at the start of each session for emergency purposes.
Confidentiality for Minors
Information will be shared with parents/guardians EXCEPT: sexual/reproductive health, substance use treatment, and when sharing would be detrimental. Danger to self/others and abuse will ALWAYS be reported.
Consent
■ MINOR CONSENT: I am 12+ and consent to telehealth mental health treatment.
Minor Signature: _____ Date: _____
■ PARENT/GUARDIAN CONSENT: I consent to telehealth treatment for my child.
Parent/Guardian Name: _____ Relationship: _____
Parent/Guardian Signature: _____ Date: _____
■ PROVIDER DETERMINATION: This minor meets CA criteria for minor consent.
Provider: _____ Signature: _____ Date: _____

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HIPAA Notice - Parent/Guardian Acknowledgement

HIPAA NOTICE OF PRIVACY PRACTICES
Effective Date: August 26, 2026
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Our Legal Duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information.
Uses and Disclosures of Health Information
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.
Psychotherapy Notes: Most uses and disclosures of psychotherapy notes require your written authorization.
Required by Law, Public Health, Abuse/Neglect, Health Oversight, Judicial Proceedings, Law Enforcement, Threat to Health/Safety, and other disclosures as permitted by HIPAA.
Your Rights
Right to Inspect and Copy, Right to Amend, Right to an Accounting of Disclosures, Right to Request Restrictions, Right to Request Confidential Communications, Right to a Paper Copy of This Notice.
Complaints
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.
Contact: Privacy Officer, Private Access Psychiatry, 20054 Crestview Dr., Canyon Country, CA 91351, Phone: 818-731-2100
I acknowledge receipt of this Notice of Privacy Practices.
Patient Name: _____ Date: _____
Signature: _____
Parent/Guardian if Minor: _____

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Financial Policy and Fee Agreement

FINANCIAL POLICY AND FEE AGREEMENT
Thank you for choosing Private Access Psychiatry. Please review our financial policies:
1. Payment is due at time of service. We accept cash, check, credit card.
2. You are responsible for knowing your insurance benefits. We will bill as a courtesy but you are responsible for non-covered services.
3. Cancellation Policy: 24-hour notice required or a $____ fee may be charged.
4. No-show appointments may be charged $____.
5. Returned checks subject to $35 fee.
6. Records requests: $25 + $0.25/page per CA law.
I have read and agree to the financial policies above.
Responsible Party Name: _____ Date: _____
Signature: _____

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Credit Card Authorization & Retainer Agreement

CREDIT CARD AUTHORIZATION & RETAINER AGREEMENT
Patient Name: _____ Date: _____
Card Information
Cardholder Name: _____
Card Type: ■ Visa ■ MasterCard ■ Amex ■ Discover
Card Number: _____ Exp: _____ CVV: _____ Billing Zip: _____
Authorization for Charges
I authorize Private Access Psychiatry to charge my credit card for:
■ Standard Services:
• Initial Psychiatric Evaluation: $3,000
• Follow-up Appointment: $1,500
• Confidential treatment consultation to assess fit: $750
■ No-show/Late Cancellation Fee: $_____ (less than 24 hours notice)
■ Records Requests, Letters, Forms: Per fee schedule
Retainer Fee Program
■ Individual Retainer: $25,000
■ Family Retainer: $50,000
Retainer covers priority access, extended sessions, and care coordination. Services rendered are billed against retainer at standard rates. Unused retainer balances are non-refundable but may be applied to future services for 12 months.
Terms
I understand that I am responsible for payment regardless of insurance coverage. I authorize charges for services rendered, no-shows, and late cancellations. I will receive receipts via email.
Cardholder Signature: _____ Date: _____

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Emergency Contact Information

EMERGENCY CONTACT INFORMATION
Patient Name: _____ DOB: _____
Primary Emergency Contact
Name: _____ Relationship: _____
Phone (Day): _____ Phone (Evening): _____
Address: _____
Secondary Emergency Contact
Name: _____ Relationship: _____
Phone (Day): _____ Phone (Evening): _____
Authorization to Contact
I authorize Private Access Psychiatry to contact the above individuals in case of emergency, concern for safety, or if unable to reach me regarding urgent clinical matters.
For minors: I understand that CA law allows limited disclosure to parents/guardians in emergencies.
Patient Signature (if 12+): _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

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Medication Informed Consent - Parent/Guardian

INFORMED CONSENT FOR PSYCHIATRIC MEDICATION
Patient Name: _____ DOB: _____ Date: _____
Medication: _____ Dose: _____
I understand that my psychiatrist has recommended the above medication for treatment of:
_____
Benefits
Potential benefits include reduction in symptoms, improved functioning, and improved quality of life. No guarantee of effectiveness is made.
Risks & Side Effects
I have been informed of potential side effects, which may include but are not limited to: nausea, weight changes, sleep changes, sexual side effects, mood changes, and rare serious effects including serotonin syndrome, NMS, or suicidal thoughts.
For patients under 25: Antidepressants may increase suicidal thinking in some individuals.
I understand I should not stop medication abruptly without consulting my provider.
Alternatives
Alternatives include other medications, psychotherapy alone, or no treatment. I have had opportunity to discuss these.
I consent to treatment with this medication and will report side effects or concerns promptly.
Patient Signature (if 12+): _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
Prescriber: _____ Date: _____

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Authorization for Release of Health Information

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
Patient Name: _____ DOB: _____
I hereby authorize Private Access Psychiatry to:
■ Release information TO: ■ Obtain information FROM:
Name/Organization: _____
Address: _____
Phone: _____ Fax: _____
Information to be Released
■ Complete Record ■ Psychiatric Evaluation ■ Treatment Summary
■ Medication Records ■ Progress Notes ■ Lab Results
■ Other: _____
Date(s) of Treatment: From _____ To _____
Purpose of Disclosure
■ Continuing Care ■ Legal ■ Insurance ■ Personal
■ Other: _____
I understand that I may revoke this authorization at any time, that information disclosed may be subject to re-disclosure, and that treatment is not conditioned on signing this authorization.
This authorization expires on: _____ or one year from date signed.
Patient/Guardian Signature: _____ Date: _____
Printed Name: _____ Relationship to Patient: _____
Witness: _____ Date: _____

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Columbia Suicide Severity Rating Scale

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) - SCREENER
Patient Name: _____ Date: _____ DOB: _____
Ask questions 1 and 2. If both are NO, skip to question 6. If YES to 2, ask 3-5.
Suicidal Ideation
1. Have you wished you were dead or wished you could go to sleep and not wake up? ■ Yes ■ No
2. Have you actually had any thoughts of killing yourself? ■ Yes ■ No
If YES to #2, ask:
3. Have you been thinking about how you might do this? ■ Yes ■ No
4. Have you had these thoughts and had some intention of acting on them? ■ Yes ■ No
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? ■ Yes ■ No
Suicidal Behavior
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? ■ Yes ■ No
If YES, was this in the past 3 months? ■ Yes ■ No
Risk Level & Action
■ Low Risk: Ideation only. Provide resources, safety plan.
■ Moderate Risk: Ideation with plan but no intent. Safety plan, remove means, increase contact.
■ High Risk: Intent with/without plan, or recent behavior. Immediate safety precautions required.
Clinical Notes: _____
_____
Clinician: _____ Signature: _____ Date: _____