Eric Wexler, M.D., Ph.D.

www.EricWexlerMD.com -- 2730 Wilshire Blvd Suite 325 Santa Monica CA, 90403 -- 310-744-5102

Adult Psychiatric Intake

Examination Date: Time:

Patient Information Summary **PLEASE PRINT -- BLACK INK ONLY**

Name | Date of Birth

Street

City | State | Zip | Choose a PIN#

TELEPHONE: *Home* | *Work* | *Fax*

Mobile | Email

Occupation | Education Level

Spouse/Partner | *Preferred Pharmacy*

Emergency Contact

Do you have any life threatening allergies? (food, medication, insects, etc) ❍*No* ❍*Yes* To what?

Have you been to the hospital, emergency room or urgent care within the past month: ❍*No* ❍*Yes*

	Name	Contact info
Primary Care MD		
Therapist (name)		
Other MD		

CHIEF COMPLAINT (specify onset and duration)

ERIC WEXLER M.D., PH.D.
ADULT PSYCHIATRY
2730 WILSHIRE BLVD, SUITE 325
SANTA MONICA, CA 90403
TEL: (310) 774-5102
FAX: (310) 919-1919

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Eric Wexler M.D., Ph.D. to exchange
NAME OF PATIENT

information pertaining to my treatment with and/or release copies of my psychiatric and medical records to:

_____
NAME OF PERSON OR TITLE OF ORGANIZATION

_____
ADDRESS AND/OR PHONE NUMBER

The relevant and timely information that may be released is limited to:

Initial Clinical Summary	Verbal Telephone Contact
Progress Notes	Medication
Laboratory Results	Consultations
Psychological Testing	Other _____

These records are required for continuity of clinical care. This release will be valid until treatment ends, unless otherwise noted.

I certify that I have read this form and that I understand its contents. I also understand that I have a right to receive a copy of this authorization upon request.

_____ _____
NAME (PLEASE PRINT) SIGNATURE

_____
DATE

ERIC M. WEXLER M.D., PH.D.
Diplomate, American Board of Psychiatry & Neurology

2730 Wilshire Blvd, Suite 325
Santa Monica, CA 90403
(TEL) 310-744-5102
(FAX) 310-919-1919
info@ericwexlermd.com
www.EricWexlerMD.com

CREDIT CARD AUTHORIZATION

Please neatly complete the following information in print with black ink.

I _____ accept full financial responsibility for the patient (or consultee) being or to be treated by Dr. Eric Wexler, whose name is _____. I authorize Eric Wexler MD, PhD Inc. to charge my credit card up to 48 hours prior to the next scheduled visit with Dr. Wexler; including for the initial visit or any part thereof, as well as, in the event that the patient fails to show for future scheduled appointments, or does not give notification of the patient's inability to attend a scheduled appointment, at least 48 business hours in advance, as agreed to in the *Treatment Consent Form*. I authorize my card to be charged for all time spent by Dr. Wexler in providing consultation services (e.g. phone calls, emails, written reports, etc.) I have read and agree to abide by the *Office Policies and Procedures*, as agreed to by the patient, in the *Treatment Consent Form*. Furthermore, for outstanding payments of services rendered I authorize Dr. Wexler to charge my credit card for the full amount due. I will not dispute the cost or charges for sessions I have received in whole or part, in person or remotely or that I have not cancelled less than 48 business hours in advance. I further authorize Dr. Wexler to disclose information about my attendance/cancellation to my credit card company if I dispute a charge.

Card Type (circle one): Visa MasterCard American Express Discover

Card #: _____ Expiration Date: _____

Security Code (see Figure below) _____

Name As Printed On Card: _____

Telephone Number Associated With Account: _____

Billing Address: _____
(Street , City , State)

Zip code: _____ EMAIL: _____

Signature: _____ Date: _____
(client or financially responsible party)

Finding your credit card's security code

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will be charged if any of the following conditions apply: "no-show" for a scheduled appointment, cancellation less than 48 business hours in advance of scheduled appointment, or participation in treatment without payment rendered (eg. appointment or phone session). A $100 fee, plus my time spent, is charged for each contested charge or returned check.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, OFFICE POLICIES AND CONSENTS

** You May Refuse to sign this Acknowledgement**

I,_____, have received a copy of Eric Wexler MD PhD INC's *Notice of*
(Print Name Above)
Privacy Practices, and *Office Policies & Procedures.* I have read these documents and agree to abide by the terms set forth therein. Treatment is strictly voluntary and you may choose to discontinue treatment any time you wish. By signing this document I give my permission to Dr. Wexler to treat me. This consent remains valid until such time as I choose to discontinue treatment, either explicitly or implicitly by failing to adhere to the expectations and terms set forth in *Office Policies & Procedures.* In accordance with these policies and terms, I hereby agree to pay for my treatment at the time of the service. I understand that I am financially responsible for all charges whether or not paid by the insurance or third party involvement. I hereby authorize Dr. Wexler release all information necessary to secure payment of benefits. I agree to abide by the policies set forth in Office Policies & Procedures, including, but not limited to those concerning financial obligations and dispute resolution.

_____ _____

Patient Signature Date

For Office Use Only

Eric Wexler MD PhD Inc. attempted to obtain written acknowledgement of receipt of his/her Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ An emergency situation prevented him/her from obtaining the acknowledgement

_____ Other (specify)

Recreational Substance Use

Have you ever used the following, and how much do you currently consume? (INCLUDE DATES OF MOST RECENT USE)

❑ **Cigarettes**	❑ **Ketamine**
❑ **Coffee**	❑ **Pain Killers**
❑ **Marijuana**	❑ **Mushrooms/Psilocybin**
❑ **Heroin**	❑ **Peyote/Mescaline** ❑ **Salvia** ❑ **Khatt**
❑ **Amphetamines**	❑ **LSD**
❑ **Cocaine**	❑ **Kratom**
❑ **Tranqs/Sleepers (e.g. "Benzos")**	❑ **Steroids**
❑ **Bath Salts/Mephedrone/Flakka**	❑ **Ecstacy/MDMA**
❑ **Nitrous Oxide**	❑ **"N-Bomb/smiles/25I"**
❑ **GHB or Rohypnol**	❑ **Glue or Solvents**
❑ **Alcohol**	❑ **Spice/K2**
❑ **"Robo"/Dextromethorphan** ❑ **Syrup or "purple drank"**	❑ **Laxatives**
❑ **PCP**	❑ **Other**

Review of Systems *(check all that apply)*

General Health: ❑ No Problems ❑ Lack of energy, ❑ unexplained weight gain or weight loss, ❑ loss of appetite, ❑ fever, ❑ night sweats, ❑ pain in jaws when eating, ❑ scalp tenderness, ❑ prior diagnosis of cancer, ❑ excessive thirst, ❑ Other general health problems:_____

Head & Neck: ❑ No Problems ❑ Difficulty with hearing, ❑ sinus problems, ❑ runny nose, ❑ post-nasal drip, ❑ ringing in ears, ❑ mouth sores, ❑ loose teeth, ❑ ear pain, ❑ nosebleeds, ❑ sore throat, ❑ facial pain or numbness, ❑ swallowing problems, ❑ coughing up blood. ❑ Other ENT problems:_____

Heart & Blood Vessels: ❑ No Problems ❑ Irregular heartbeat, ❑ racing heart, ❑ chest pains, ❑ swelling of feet or legs, ❑ pain in legs with walking. ❑ Other cardiovascular problems:_____

Lungs & Breathing: ❑ No Problems ❑ Shortness of breath, ❑ night sweats, ❑ prolonged cough, ❑ wheezing, ❑ sputum production, ❑ prior tuberculosis, ❑ pleurisy, ❑ oxygen at home, ❑ coughing up blood, ❑ abnormal chest x-ray. Other respiratory problems:_____

Stomach & Intestines: ❑ No Problems Heartburn, ❑ constipation, ❑ intolerance to certain foods, ❑ diarrhea, ❑ abdominal pain, ❑ difficulty swallowing, ❑ nausea, ❑ vomiting, ❑ blood in stools, ❑ unexplained change in bowel habits, ❑ incontinence. Other GI problems:_____

Urinary Tract & Genitals: ❑ No Problems Kidney Stones, ❑ Painful or frequent urination, ❑ urgency, ❑ prostate problems, ❑ bladder problems, ❑ impotence or other sexual problems. Other:_____

Muscles, Bones, Joints: ❑ No Problems Joint pain, ❑ aching muscles, ❑ shoulder pain, ❑ swelling of joints, ❑ joint deformities, ❑ back pain. Other musculoskeletal problems:_____

Skin, Hair & Breast: ❑ No Problems Persistent rash, ❑ itching, ❑ new skin lesion, ❑ change in existing skin lesion, ❑ hair loss or increase, ❑ breast changes. Other integument problems:_____

Brain & Nerves: ❑ No Problems Frequent headaches, ❑ double vision, ❑ weakness, ❑ change in sensation, ❑ problems with walking or balance, ❑ dizziness, ❑ tremor, ❑ loss of consciousness, ❑ uncontrolled motions, ❑ episodes of visual loss. Other neurological problems:_____

Mood & Thinking: ❑ No Problems Insomnia, ❑ irritability, ❑ depression, ❑ anxiety, ❑ recurrent bad thoughts, ❑ mood swings, ❑ hallucinations, ❑ obsessions/compulsions. Other psychiatric:_____

Glands: ❑ No Problems Intolerance to heat or cold, ❑ menstrual irregularities, ❑ frequent hunger/urination/thirst, ❑ changes in sex drive. Other endocrinologic problems:_____

Blood & Lymph: ❑ No Problems Easy bleeding, ❑ easy bruising, ❑ anemia, ❑ abnormal blood tests, ❑ leukemia, ❑ unexplained swollen areas. Other hematologic problems:_____

Allergic, Infectious or Immune: ❑ No Problems ❑ Seasonal allergies, ❑ hay fever symptoms, ❑ itching, ❑ frequent infections, ❑ exposure to HIV or hepatitis, ❑ recent infection; viral, ❑ bacterial or fungal. ❑ Other immunological problems:_____

❑ Any other symptoms not described above:____

Psychiatric History

Have you ever received any previous psychiatric or psychological evaluation or treatment? ❍*No* ❍*Yes*

Year	Doctor	Clinic or Hospital	Reason	Medication Used (if any)

Have you ever attempted suicide? ❍*No* ❍*Yes* If yes, please describe when, how, and what happened.

Have you or anyone in your immediate family (parents, brothers/sisters, children, aunts/uncles, grandparents) been diagnoses with any of the following conditions that may have a genetic component.

Disorder	**Me (age of onset)**	**Family Member (+age of onset)**
Bipolar Disorder (mania)		
Major Depression		
Obsessions-Compulsions (OCD)		
Panic Attacks		
PTSD		
Schizophrenia/Schizoaffective		
Anorexia/Bulimia		
Autism/Asperger's		
ADHD		
Epilepsy		
Lupus		
Leukodystrophy		
Other Autoimmune Disease		
Multiple Sclerosis		
Parkinson's Disease		
Alzheimer's Disease		
Frontotemporal Dementia		
Lewy Body Disease		
Huntington's Disease		
Wilson's Disease		
Porphyria		
Mad Cow (prion disease)		
Early-onset Dementia		
Tourette's Syndrome		
Ataxia		
Other		

Currently Perscribed Medications

Medication	Dose/Frequency	Duration	Side-Effects or adverse events

Current Over-the-counter Medications (or other perscribed medications not listed above)

Current Nutritional Supplements

Psychiatric Medications Used in Past (Commonly used medications are listed on the next page)

Medication	Dose/Frequency	Duration	Benefits Effects OR Unwanted Side-Effects/Adverse events

Please check all psychotropic medications that you have used in the past, writing date of last use to RIGHT of drug name.

- ❑ Symbyax (Prozac+Zyprexa)
- ❑ Abilify/Aripiprazole
- ❑ Clozaril/Clozapine
- ❑ Fanapt/Iloperidone
- ❑ Prolixin/Fluphenazine
- ❑ Geodon/Ziprasidone
- ❑ Haldol/Haloperidol
- ❑ Invega/Paliperidone
- ❑ Latuda/Lurasidone
- ❑ Vraylar/Cariprazine
- ❑ Solian/Amisulpride
- ❑ Dogmatil/Sulpride
- ❑ Loxitane/Loxapine
- ❑ Moban/Molindone
- ❑ Navane/Thiothixene
- ❑ Orap/Pimozide
- ❑ Trilafon/Perphenazine
- ❑ Risperdal/Risperidone
- ❑ Seroquel/Quetiapine
- ❑ Stelazine/Trifluoperazine
- ❑ Melaril/Thiorodizine
- ❑ Thorazine/Chlorpromazine
- ❑ Zyprex/Olanzapine
- ❑ Saphris/Asenapine
- ❑ Anafranil/Clomipramine
- ❑ Asendin/Amoxapine
- ❑ Aventyl/Nortriptyline
- ❑ Celexa/Citalopram
- ❑ Cymbalta/Duloxetine
- ❑ Desyrel/Trazodone
- ❑ Effexor/Venlafaxine
- ❑ Elavil/Amitriptyline
- ❑ Emsam/Selegiline
- ❑ Lexapro/Escitalopram
- ❑ Ludiomil/Maprotiline
- ❑ Luvox/Fluvoxamine
- ❑ Marplan/Isocarboxazid
- ❑ Nardil/Phenelzine
- ❑ Norpramin/Desipramine
- ❑ Pamelor/Nortriptyline
- ❑ Parnate/Tranylcypromine
- ❑ Paxil/Paroxetine
- ❑ Pexeva/Paroxetine -
- ❑ Pristiq/Desvenlafaxine
- ❑ Prozac/Fluoxetine
- ❑ Remeron/Mirtazapine
- ❑ Sarafem/Fluoxetine
- ❑ Sinequan/Doxepin
- ❑ Surmontil/Trimipramine
- ❑ Tofranil/Imipramine
- ❑ Vivactil/Protriptyline
- ❑ Wellbutrin/Bupropion
- ❑ Fetzima/Levomilnacipran
- ❑ Viibryd/Vilazodone
- ❑ Trintellix/Vortioxetine
- ❑ Serzone/Nefazodone
- ❑ Deseryl/Trazodone
- ❑ Zoloft/Sertraline
- ❑ Depakote/Valproic Acid
- ❑ Eskalith/Lithium Carbonate
- ❑ Lamictal/Lamotrigine
- ❑ Lithobid/Lithium Carbonate
- ❑ Neurontin/Gabapentin
- ❑ Tegretol/Carbamazepine
- ❑ Topamax/Topiramate
- ❑ Trileptal/Oxcarbazepine
- ❑ Gabitril/Tiagabine
- ❑ Keppra/Levetiracetam
- ❑ Dilantin/Phenytoin
- ❑ Lyrica/Pregabalin
- ❑ Savella/Milnacipran
- ❑ Zonegran/Zonisamide
- ❑ Xyrem/Sodium Oxybate
- ❑ Felbatol/felbamate
- ❑ Zarontin/Ethosuximide
- ❑ Ativan/Lorazepam
- ❑ Buspar/Buspirone
- ❑ Klonopin/Clonazepam
- ❑ Librium/Chlordiazepoxide
- ❑ Serax/Oxazepam
- ❑ Tranxene/Clorazepate
- ❑ Valium/Diazepam
- ❑ Xanax/Alprazolam
- ❑ Sonata/Zaleplon
- ❑ Ambien/Zolpidem
- ❑ Lunesta/Eszopiclone
- ❑ Rozarem/Ramelteon
- ❑ Vistaril/Hydroxyzine
- ❑ Suboxone/Buprenorphine
- ❑ Parlodel/bromocriptine
- ❑ Ketamine
- ❑ OTHER
- ❑ Eldepryl/selegiline
- ❑ Cogentin/benztropine
- ❑ Symmetrel/amantadine
- ❑ Comtan/entacapone
- ❑ Requip/ropinirole
- ❑ Mirapex/pramipexole
- ❑ Apokyn/apomorphine
- ❑ Neupro/rotigotine transdermal
- ❑ Parcopa/carbidopa+levodopa
- ❑ Parlodel/bromocriptine
- ❑ Permax/pergolide
- ❑ Stalevo/carbidopa+LDopa+entacapone
- ❑ Artane/trihexyphenidyl
- ❑ Azilect/rasagiline
- ❑ Benadryl/Diphenhydramine
- ❑ Chantix/Varenicline
- ❑ Antabuse/Disulfuram
- ❑ InderalPropranolol
- ❑ Cytolmel/T3
- ❑ Synthroid/T4
- ❑ Levoxyl/T4
- ❑ Almotriptan/Axert
- ❑ frovatriptan/Frova
- ❑ rizatriptan/Maxalt
- ❑ zolmitriptan/Zomig
- ❑ Cafergot
- ❑ Midrin
- ❑ Eletriptan/Relpax
- ❑ Naratriptan/Amerge
- ❑ Sumatriptan/Imitrex
- ❑ Fiorinal
- ❑ Dihydroergotamine/DHE 45
- ❑ Adderall/Amphetamine
- ❑ Concerta/Methylphenidate
- ❑ Daytrana/Methylphenidate Patch
- ❑ Desoxyn/Methamphetamine
- ❑ Dexedrine/Dextroamphetamine
- ❑ Dextrostat/Dextroamphetamine
- ❑ Focalin/Dexmethylphenidate
- ❑ Intuniv/Guanfacine
- ❑ Metadate ER/Methylphenidate
- ❑ Ritalin/Methylphenidate
- ❑ Strattera/Atomoxetine
- ❑ Vyvanse/Lisdexamfetamine
- ❑ Other

Medical History

Have you ever had to be hospitalized? ❍*No* ❍*Yes* *If yes, please complete the following:*

Year	Doctor's Name	Name of Hospital	Name of Operation or Procedure

What is your current weight? *(estimate if you do not know exactly)*

What is the most you have ever weighed? When?

MEDICATION ALLERGIES: ❍*No* ❍*Yes*

Medication	Adverse Reaction

Have you ever had food allergies? ❍*No* ❍*Yes* *If yes, please describe*

FOR WOMEN ONLY:

Date your last menstrual period began

Number of pregnancies

Number of children born alive

Number of therapeutic abortions

Number of miscarriages or stillbirths

Have you had a Pap smear within the last year? ◯ *No* ◯ *Yes*

Do you use any contraceptive method? ◯ *No* ◯ *Yes* If yes, which?

Do you examine your breasts for lumps? ◯ *No* ◯ *Yes*

Have you recently had any of the following tests? If yes, when and why?

❑ Physical Exam	Date		Purpose	
❑ Blood Tests	Date		Purpose	
❑ Chest X-ray	Date		Purpose	
❑ Electrocardiogram (EKG)	Date		Purpose	
❑ Brain Scan (MRI, CT)	Date		Purpose	
❑ EEG	Date		Purpose	

Diagnoses you have received, at any time in the past, writing dates to RIGHT of diagnosis. *(please check all that apply)*

Autoimmune Diseases
- ❑ Celiac disease (sprue)
- ❑ Dermatomyositis
- ❑ Lupus
- ❑ Pernicious anemia
- ❑ Rheumatoid arthritis
- ❑ Sjogren syndrome
- ❑ Other Autoimmune Disease
- ❑ Polyarthralgia rheumatica
- ❑ Scleroderma

Cardivascular/Heme
- ❑ High Cholesterol
- ❑ Claudication
- ❑ High Blood Pressure
- ❑ Heart failure/CHF
- ❑ Arrhythmia
- ❑ Heart defect
- ❑ Anemia
- ❑ Sickle-cell Anemia
- ❑ Porphyria
- ❑ Phenylketonuria (PKU)
- ❑ metabolic disorder

Endocrine
- ❑ Goiter
- ❑ Thyroid Disease
- ❑ Other Hormone Problem
- ❑ Diabetes
- ❑ Pituitary problems
- ❑ Cushing's syndrome
- ❑ Addison's disease
- ❑ Graves disease
- ❑ Hashimoto's thyroiditis

ENT/Misc
- ❑ Glaucoma
- ❑ Severe Cuts or Lacerations
- ❑ Broken Bones
- ❑ Amputation
- ❑ Drug Poisoning
- ❑ Toxic Exposures
- ❑ Reflex Sympathetic dystrophy
- ❑ Fibromyalgia
- ❑ Cancer *(Any type)*

GI
- ❑ Peptic (Stomach) Ulcers
- ❑ Diabetes
- ❑ Colitis
- ❑ Cirrhosis
- ❑ Pancreatitis
- ❑ Irritable Bowel
- ❑ Diverticulitis
- ❑ Diverticulosis
- ❑ Ulcerative colitis
- ❑ Crohn's disease
- ❑ Hemorrhoids

GU
- ❑ Endometriosis
- ❑ Urinary incontinence
- ❑ Hysterectomy
- ❑ Oophrectomy
- ❑ Birth Defects
- ❑ Other gynecological
- ❑ Sexual dysfunction
- ❑ Painful intercourse
- ❑ Kidney stones

Infections
- ❑ Blood Infection
- ❑ Parasite infection
- ❑ Whipple's disease
- ❑ HIV
- ❑ Lyme Disease
- ❑ Herepes/Shingles
- ❑ Hepatitis
- ❑ Malaria
- ❑ Gonorrhea
- ❑ Syphilis
- ❑ Chlamydia
- ❑ UTI
- ❑ Pneumonia
- ❑ Chagas
- ❑ Tuberculosis
- ❑ Rheumatic Fever
- ❑ Scarlet fever
- ❑ Mumps
- ❑ Measles
- ❑ Rubells
- ❑ Chicken pox
- ❑ Tularemia
- ❑ Psitacosis
- ❑ Other STD

Neurological
- ❑ Ataxia
- ❑ Head Injury
- ❑ Headaches
- ❑ Meningitis
- ❑ Epilepsy
- ❑ Stroke
- ❑ Lewy Body Disease
- ❑ Parkinson's Disease
- ❑ Leukodystrophy
- ❑ Tourette's Syndrome
- ❑ Early Dementia
- ❑ Wilson's Disease
- ❑ Multiple Sclerosis
- ❑ Mad Cow (prion disease)
- ❑ Frontotemporal Dementia
- ❑ Huntington's Disease
- ❑ Alzheimer's Disease
- ❑ Encephalitis
- ❑ Multiple sclerosis
- ❑ Myasthenia gravis

Psychiatric
- ❑ ADHD
- ❑ Schizophrenia-Schizoaffective
- ❑ Obsessions-Compulsions (OCD)
- ❑ Autism-Asperger's
- ❑ PTSD
- ❑ Major Depressive Disorder
- ❑ Anorexia-Bumia
- ❑ Panic Attacks
- ❑ Bipolar Disorder (mania)
- ❑ Conversion Disorder
- ❑ Intermittent Explosive Disorder
- ❑ Trichotillomania
- ❑ Pyromania
- ❑ Compulsive Gambling
- ❑ Kleptomania
- ❑ Sexual disorder
- ❑ Sex addiction
- ❑ Other addiction
- ❑ Substance Abuse-addiction
- ❑ Dissociative disorder
- ❑ Personality disorder

Resipiratory
- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Pulmonry fibrosis

Family Background and Childhood History:

Were you adopted? ○ Yes ○ No. Where did you grow up? _____

List your siblings and their ages: _____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ○ Yes ○ No. If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him. _____

Describe your mother and your relationship with her. _____

How old were you when you left home? _____

Has anyone in your immediate family died? ○ Yes ○ No. _____

Did you ever have irresistible urges to hurt, attack, kill someone or destroy their property?

Did you ever gamble, whether you can afford to or not?

Have you ever had the experience of:

- ❑ Finding yourself in a place and having no idea how you got there
- ❑ Minutes, hours or days having gone by without any memory of what has happened during that time
- ❑ Having no memory for some important events in your life (for example, a graduation, wedding, death)

Trauma History:

❑ Have you suffered serious injury from war, accent or natural disaster ○ Yes ○ No.

❑ Have you ever filed a personal injury, or workman's compensation or medical malpractice lawsuit? ○ Yes ○ No

❑ Were you subject to physical, sexual or verbal abuse ○ Yes ○ No. If so, please describe when, where and by whom _____

_____.

Educational History:

What is your highest educational level or degree attained? _____

Did you attend college? ○ Yes ○ No. Where? _____ Major _____

Occupational History:

Are you currently: ○ Working, ○ Not working by choice, ○ Unemployed, ○ Disabled, ○ Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? _____ If so, what branch and when? _____

❑ Honorable Discharge ❑ Medical Discharge ❑ Dishonorable Discharge

❑ Arrested for any reason: ❑ Prison ❑ Jail Was the crime violent Yes/No. Dates incarcerated _____

Relationship History and Current Family:

Have you ever been in a long-term romantic relationship?

Are you currently: ○ Married ○ Divorced ○ Single ○ Widowed. How long? _____

If not married, are you currently in a relationship? ○ Yes ○ No. If yes, how long? _____

Are you sexually active? ○ Yes ○ No. How would you identify your sexual orientation _____

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? Yes/No If so, how many? _____ How long? _____

Do you have children? ( ) Yes ( ) No. If yes, list ages and gender _____

Describe your relationship with your children: _____

List everyone who currently lives with you? _____

Have you recently experienced any stressful life events (in last 2 years):

❑ Marriage or engagement	❑ Personal injury or illness
❑ Separation or divorce Sexual difficulties	❑ Breakup of important relationship
❑ Changes in school, work	❑ Death of close family, friend
❑ Changes in residence	❑ Child left home
❑ Financial disorder	❑ Bad health of family, friend
❑ Legal difficulties	❑ Other

Depression

Instructions: Put a check (√) to indicate how much you have experienced each symptom during the past week, including today.		Absent	Somew	Moderat	A lot	Extreme
		0	1	2	3	4
THOUGHTS AND FEELINGS	1. Feeling sad or down in the dumps					
	2. Feeling unhappy or blue					
	3. Crying spells or tearfulness					
	4. Feeling discouraged					
	5. Feeling hopeless					
	6. Low self-esteem					
	7. Feeling worthless or inadequate					
	8. Guilt or shame					
	9. Criticizing yourself or blaming others					
	10. Difficulty making decisions					
ACTIVITIES AND PERSONAL RELATIONSHIPS	11. Loss of interest in family, friends or colleagues					
	12. Loneliness					
	13. Spending less time with family or friends					
	14. Loss of motivation					
	15. Loss of interest in work or other activities					
	16. Avoiding work or other activities					
	17. Loss of pleasure or satisfaction in life					
PHYSICAL SYMPTOMS	18. Feeling tired					
	19. Difficulty sleeping or sleeping too much					
	20. Decreased or increased appetite					
	21. Loss of interest in sex					
	22.Worrying about your health					
SUICIDAL URGES	23. Do you have any suicidal thoughts?					
	24. Would you like to end your life?					
	25. Do you have a plan for harming yourself?					

Anxiety

Instructions: Put a check (√) to indicate how much you have experienced each symptom during the past week, including today.		Absent	Somewhat	Moderately	A lot	Extremely
		0	1	2	3	4
ANXIOUS FEELINGS	Anxiety, nervousness, worry, or fear					
	Feeling things around you are strange or foggy					
	Feeling detached from all or part of your body					
	Sudden unexpected panic spells					
	Apprehension or a sense of impending doom					
	Feeling tense, stress, “uptight"					
ANXIOUS THOUGHTS	Difficulty concentrating					
	Racing thoughts					
	Frightening fantasies or daydreams					
	Feeling on the verge of losing control					
	Fears of cracking up or going crazy					
	Fears of fainting or passing out					
	Fears of illnesses, heart attacks or dying					
	Fears of looking foolish in front of others					
	Fears of being alone, isolated or abandoned					
	Fears of criticism or disapproval					
	Fears that something terrible will happen					
PHYSICAL SYMPTOMS	Skipping, racing or pounding of the heart					
	Pain, pressure or tightness in the chest					
	Tingling or numbness in the toes or fingers					
	Butterflies or discomfort in the stomach					
	Constipation or diarrhea					
	Restlessness or jumpiness					
	Tight, tense muscles					
	Sweating not brought on by heat					
	A lump in the throat					
	Trembling or shaking					
	Rubbery or “jelly” legs					
	Feeling dizzy. Lightheaded or off balance					
	Choking or smothering sensations					
	Headaches or pains in the neck or back					
	Hot flashes or cold chills					
	Feeling tired, weak or easily exhausted					

Eric Wexler MD, PhD
ADULT PSYCHIATRY & FORENSIC EVALUATION
2730 Wilshire Blvd, Suite 325
Santa Monica CA 90403
TELEPHONE: 310-744-5102
FAX: 310-919-1919
ewexler@modernbrains.com

OFFICE POLICIES AND PROCEDURES

Welcome

Below is information about my practice, which will help you get started with an initial evaluation and, possibly, treatment. Please take a moment to read over the following information about my policies and complete the forms prior to your first appointment (you may fax, email or bring them with you to your first appointment). By scheduling an initial appointment you are entering into an agreement for me to provide a psychiatric evaluation service to you and in exchange you agree to abide by the policies and procedures outlined below (e.g. paying for this or future appointments even if missed, not disturbing other patients in the waiting room, etc)

Initial Evaluations. An initial evaluation for generally takes 90 minutes if the new patient forms are completed and returned in advance of your appointment. These include two types of documents, in PDF format: Administrative and New Patient: History. These provide me with an overview about your medical and social history and improve the efficiency of your first visit. Please understand that the aim of this initial session is to provide an assessment of your mental health needs and to determine the best available treatment options, which may include referral to another provider. *The evaluation is not an agreement that I will take you on as a patient.*

Location: I have relocated my practice from UCLA-Westwood to Santa Monica, effective September 1st, 2012. I am now conveniently located at 2730 Wilshire Blvd, Suite 325, at the southeast corner of Wilshire Blvd and Harvard street (two blocks past 26th street)

Parking Metered street parking is often readily available. However, for convenience you may also choose to park in the building's private underground lot, at an additional parking charge (enter from Harvard street)

Directions

Malibu: Proceed south of the PCH. At the Santa Monica Pier bear left onto I-10 East. Use Exit 1B to exit onto 20th st. Turn left onto 20th street, then right onto Wilshire Blvd.

Downtown LA-Pasedena: Take 110 South to I-10 West. Use Exit 1C "Cloverfiled Blvd/26th street". Turn left onto Cloverfield then bear left onto 26th Street. Turn right onto Wilshire Blvd, your destination will be two blocks ahead on the right side.

San Fernando Valley: Take the 405 South (East) to I-10 West. Use Exit 1C "Cloverfiled Blvd/26th street". Turn left onto Cloverfield then bear left onto 26th Street. Turn right onto Wilshire Blvd, your destination will be two blocks ahead on the right side.

Beverly Hills, Century City, Brentwood, Westwood, Bel Air: You may prefer to use local streets to get here. Please keep in mind that during busy times of the day Google maps is not always correct. Wilshire Blvd is usually preferable to Santa Monica Blvd because the timing of the traffic lights on the latter slows down the flow of cars.

When you arrive: Once you enter the building take the elevator to the third floor, then turn right and proceed to the end of the hallway. Once inside the waiting room, press the light next to the nameplate for Eric Wexler, M.D. to alert me that you have arrived

Appointments: Ongoing psychotherapy sessions are scheduled weekly and last 50 minutes. Medication management (pharmacotherapy) visits are scheduled for 25- or 40-minute appointments, depending upon your needs. The appointment time is reserved for you so it is important that you are on time. If you are late, your appointment may still conclude at the end of your scheduled appointment time. If significantly late, you may have to reschedule your appointment and will be charged my usual fees.

48-Hour Cancellation Policy (Including initial visit) The scheduled appointment time is reserved specifically for you/your child and this is your time. Therefore, if you are unable to keep an appointment, please be sure to cancel at least 48 hours in advance or you will be charged my usual fee for that session. Please be aware that insurance companies generally do not reimburse for a cancelled session. For urgent appointment, those scheduled less than 48 hours prior to the appointment; you are responsible for the full initial visit fee. Similarly, if you terminate a visit prior to its scheduled end time you are still responsible for the full visit fee. In other words, you are paying to reserve my time in exchange for my expertise and advice, how you choose to use it is your choice and I respect it.

Payments and Reimbursement Payment of fees is expected at the time of service; methods of payment include credit card (Mastercard Visa AMEX or Discover), cash or check. ACH or wire transfers are reserved for payment of larger fees.

Most services are billed at a rate of $500-600/hr, before any applied discounts or travel surcharges. These rates apply only to "doctor-patient" type service and do not apply to forensic services (e.g. evaluations, testimony in court or by deposition, expert consulting) or other business-type consulting. Any discounts are predicated on the patient maintaining a valid credit card on file in perpetuity or a retainer of $1000 (refundable upon termination), to insure against non-payment of future visits.

I reserve the right to charge on a "time-spent" basis, not on a per service basis. In other words, at my sole discretion, I will charge you based on how much time I spend on *your* care, not necessarily the time I spend talking with you. By extension this includes any time spent communicating with other providers of medical or legal services (e.g. conference calls, written reports, depositions). Consultations of significant length occurring between office appointments are billed at the same rate as an office visit, independent of their mode of communication. "Significant" is defined at my sole discretion; however, I often waive fees for individual phone calls less than 5 minutes, fewer than 2 calls per week and total time spent less than 15 minutes between visits. "Calls" are defined as any form of communication, including, but not limited to telephone, video, email, written letter, preparation of written reports, etc. The final charges billed to you are rounded up or down to the nearest 5 minutes. I reserve the right to "bulk or bundle-bill," the practice of pooling time spent on several small matters into a single charge (e.g. if you call me 6 days in a row and each call last 4 minutes, I will charge you for 30 minutes (6 calls rounded up to 5 minutes each).

Insurance. I am not on insurance panels, and would be considered an "out-of-network" provider under the terms of your insurance policy. If you elect to seek reimbursement from your insurance company for my services, I will provide a monthly statement that you can submit to your insurance company. You are responsible for collecting reimbursement from your insurance company or other funding source, and for negotiating any claims. You are solely responsible for payment of your medical care, regardless of what your insurance company agrees to reimburse. If you seek reimbursement and your insurer sends the reimbursement check to me I will void the check and return it to the insurer. I cannot accept these checks and transfer the money to you because of the financial (and administrative) liability incurred – I apologize for this inconvenience.

Disclosures to carriers: Most insurance companies require information about your diagnosis, the type of service provided, the date of the session, and fees. I will include this information on your statement, at your request. In some cases, insurance companies require that the physician send information about the patient's diagnosis and treatment plan, progress reports, and other records. Almost all insurance companies state that they will keep this information confidential, but I cannot assure this. For example, some may share the information they receive with a national medical information data bank for the purposes of deciding eligibility for future life, disability, health, and other insurance. Before I send any information to an insurance company, I will talk with you first, discuss the information to be provided, and obtain your written permission to do so. You have a choice about whether to release medical information requested by an insurance carrier, but if you refuse to have information released, most insurance programs will not reimburse for services.

Prior Authorizations: More and more often insurance carriers are either denying coverage of medications outright or requiring "Prior Authorization or PA." I cannot guarantee that a medication I prescribe will be covered by your insurance plan. I will make a reasonable effort to obtain prior authorization of your prescription, but I cannot guarantee it, nor can I devote unlimited resources towards doing so. I will complete any physician-mandated forms, however, I (staff) cannot spend HOURS on hold waiting for a clerk at the carrier to fax the forms to me. (Naturally, if you have them faxed to me at 310-919-1919 I will complete them and fax them back to the carrier)

Record Keeping I maintain a clinical chart for each patient, as required by the standards of my profession. Information in the chart includes a description of you/your family member's condition, diagnosis, treatment and progress. An entry is made for each appointment, as well as for phone communications. I keep records that may include any consent, information release, assessment, insurance documents, outside treatment/testing, or other records completed or collected during the course of treatment. Clinical records are kept in a locked cabinet and/or as password-protected files. Information contained in this record will not be released without your written consent except in the circumstances outlined below and as explained in the Notice of Privacy Practices.

Prescriptions It is my policy to only write and refill prescriptions for psychotropic medications when you (the patient) seen in person at a scheduled appointment. In emergency cases, I may authorize medication refills by phone or fax to your pharmacy, but generally I like to see my patients for regular, at least monthly, appointments. If you need a prescription "called" in before your next regular appointment, please give me at least a week to process your request. This will prevent any interruption in your medication use. It is best to contact your pharmacy directly when you need a medication refill, and they will fax me a refill request form. "called in" refers to any electronic communication with the dispensing pharmacy. Almost all prescription are delivered through electronic prescribing or electronic controlled prescribing and as such you give permission for the full functional use of this software. Individuals wishing to opt out of electronic prescribing will be charged a $1000 per year administrative fee to cover the additional administrative inconvenience and should be aware that some controlled substance can only be prescribed electronically.

Phone Calls If you need to reach me between appointments, please call 310-744-5102 and leave a message with your telephone number, even if you think I have it, and some times when you may be reached. Phone consultations lasting over 5 minutes are subject to a fee (See *Payments and Reimbursement* above). Please consider the need for a more immediate appointment if a longer conversation is necessary.

E-mail Correspondence You are welcome to send non-urgent information to me by e-mail, but I cannot guarantee the confidentiality or security of e-mail correspondence (for example, from hackers) despite my use of password-protected electronic mail.

Video Conferencing. Video sessions (e.g. Skype, Facetime) are inherently less secure than face to face meetings. For example the popular services record sessions on their servers. By requesting a video session you are (1) acknowledging the higher probability that others may gain access to personal information about you, and (2) waiving your rights and protections under HIPPA, and (3) giving your active consent to have your protected health information (e.g. name, voices, life details) recorded by me, by the video service conferencing service; thereby effectively releasing this information to all parties affiliated with me or the video conferencing service.

Text Messaging "Texting" is NOT HIPPA compliant (1) Text messaging it is NOT encrypted, (2) Text messaging cannot show full audit trails of when the messages are received and read, and (3) Text messaging cannot ensure priority delivery; a message about a patient in critical condition could be in the queue hidden behind other nonsense messages. Therefore, text messaging is not appropriate for communications related to your clinical information, including, but not limited to your diagnosis, treatment plans, medications, lab results, side effects or symptoms, etc.

Urgent or Emergency Issues I will do my best to respond to phone calls as soon as possible; however, I do not provide urgent, crisis or emergency services. In the event of an urgent need outside of an appointment, please contact the local emergency room, crisis intervention services, or call 911. On the occasion that I am away from my practice, the message on my voicemail will direct you to the doctor providing coverage for my practice.

Ending Treatment You may withdraw from treatment at any time. I recommend that we discuss a plan to terminate care before doing so, so that we have the opportunity to discuss further treatment recommendations, any potential risks for ending treatment at that time, and referral options if they are needed. Failure to schedule or attend followup visits will be considered *de facto* your unilateral termination of care.

Confidentiality (Summary) Information shared between patient and provider is strictly confidential, with certain exceptions required by law. You hold the privilege of deciding with whom I may disclose information about evaluation and treatment. If you would like for me to share information with other providers, therapists, school officials, or other persons, please fill out an Authorization for Release of Information for each person/entity with whom you would like me to communicate. In sum, I will release information only with your written permission with the following exceptions: (1) suspected abuse or neglect of a minor, elder or dependent individual; (2) a patient is in imminent danger of harm, actively or passively, to themselves or others; (3) a patient communicates a serious threat of physical violence against another person; (4) a parent or guardian is unable to adequately provide for a child's, or other dependent's basic needs; (5) to coordinate with other prescribing physicians when a CURES search, which is mandated by the State of California, reveals potential harm due to interaction or functional duplication of scheduled medications; (6) records are ordered to be released by a judge or court; and/or as otherwise required by law.

NOTICE OF HIPAA PRIVACY POLICY: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The following is the privacy policy ("Privacy Policy") of Eric Wexler M.D. as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information.

We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information

in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities. Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another. Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include: (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. Examples of instances in which we are required to disclose your personal health information include: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions On Use Or Disclosure You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. You may request restrictions on the following uses or disclosures: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or dea th; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar

forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right to Receive Confidential Communications You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right to Inspect and Copy Your Personal Health Information Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, except for (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We may provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format, unless such right in advance. As a condition of entering into treatment with Dr. Wexler you accept that we may provide you with a summary of the personal health information requested, in lieu of providing copies of or access to the full medical record, process notes or other personal health information collected on your behalf and agree in advance to the fees imposed for such summary or explanation. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right to Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Eric Wexler MD, PhD, 2730 Wilshire Blvd Suite 325, Santa Monica CA 90403. .

Right to Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description

of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. We are not required to provide accountings of disclosures for the following purposes: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Eric Wexler MD, PhD, 2730 Wilshire Blvd Suite 325, Santa Monica CA 90403.

Complaints You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail Eric Wexler MD, PhD, 2730 Wilshire Blvd Suite 325, Santa Monica CA 90403. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Eric Wexler MD, PhD, 2730 Wilshire Blvd Suite 325, Santa Monica CA 90403. For any other requests or for further information regarding the privacy of your personal health information, please contact us Eric Wexler MD, PhD, 2730 Wilshire Blvd Suite 325, Santa Monica CA 90403. .

Other FAQs.

What kind of patients/problems do you see in your practice?

I am an adult psychiatrist and psychopharmacologist with a special interest in mood and psychotic disorders (e.g. Bipolar or Schizophrenia). I offer evaluation and treatment services to patients 18 and older. I also offer specialized consultations to patients with concurrent neurological problems.

Can you see me for medications if I am currently seeing another therapist? Another psychiatrist?

Yes. I am glad to meet with you for medication consultation and management sessions if you are concurrently seeing another psychotherapist. In fact, more than half of my current patients are referred to me by their therapist. Similarly, I am happy to provide ”second opinion” type consultations, but you can have only one treating psychiatrist (i.e. only one physician can be prescribing your medications.

How soon can I be seen, I really need help.

My policy is to see patients within two business days and often the same day, as needed. Evening and sometimes weekend appointments are also available for urgent evaluations.

How long will I need treatment and how often will you need to see me?

You never "need" to be in treatment. The care I provide is designed to improve your quality of life. You should only want to remain in treatment as long as you are getting meaningful benefits from it. Unfortunately, there is no simple answer to how long this will last. It is high specific to each individual and is determined by the nature and severity of symptoms. For example, patients suffering from panic attacks may require only a few months of psychotherapy while an individual with schizophrenia should probably remain on thier medications for life. After the initial evaluation, I am usually able to give a much better idea of what durtion of treatment would be optimal.

If you have any questions about these policies or any of the information above, I would be happy to discuss them with you in further detail. Thank you.