Maitri Medical Center

Evaleen Jones, MD

445 Burgess Drive, Suite #150 Menlo Park, CA 94025

Phone: (650) 208-6565 Fax: (650) 327-0738

Patient Registration

Name ________________________________ Date ___________________

Birth Date _________________ M__ F__ Age ___________________

Address ____

City ___________________________ State _________________ Zip __________

Phone: (Mobile) ___________ (Work) ___________ (Home) ______________

Occupation _____________________ Employer ____________________________

Driver's License ____________________ SS#______________________________

Spouse's Name ___________________________ Phone ___________________

If under 18 years, Parent/Guardian Name __________________

Do you authorize medical treatment to minor without your

presence? _Yes/No___ Signature ____________________________________

Emergency Contact (other than spouse) _________________________________

Insurance Information

If you have insurance, a copy of your card will be made for our records at your first appointment and then updated as insurance information changes. Please inform us of any address or phone number changes as well.

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Fees: My fee is $250 for each 50 minute session.

Cancellation Policy: There is no charge for cancelled sessions when you provide 24 hours advanced notice. Otherwise, the full session fee will be charged for broken appointments or late cancellations.

Payment: All balances are due in full by cash or check to MAITRI MEDICAL at each session. Please discuss in advance if you need to make alternate arrangements for payment.

Insurance: We will provide you with a monthly statement that you can use for insurance or tax purposes. You must negotiate with your insurance carrier. Be aware that you are financially responsibly for all charges incurred whether or not paid by identified insurance company. However, let us know if you have any problems with acceptance of a claim.

Confidentiality: All consultations and records are confidential. In order to protect your privacy, billings are given or mailed to you directly. We do not email, fax, or transmit health records by any electronic mode. Further, no one will be advised of your participation in counseling unless you specifically request it, in writing. The law provides certain exclusions for confidentiality, including:

1. **Child Abuse:** When there is knowledge of or reasonable suspicion that a child has been a victim of abuse, neglect, mental suffering or a child's emotional well-being is endangered.
2. **Adult or Domestic Abuse:** When there is knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult.
3. **Health Oversight:** When the California Board of Psychology or the Board of Behavioral Science Examiners subpoenas information relevant to a complaint.
4. **Judicial or Administrative Proceeding:** In court proceedings, and when a request is received about the professional services that have been provided, health information may be disclosed with 1) written authorization or the authorization of the patient's attorney or personal representative; 2) a court order; or 3) a 'subpoena duces tecum' (a subpoena to produce records) when the party seeking information provides a showing that the patient or patient's attorney have been served with a copy of a subpoena, affidavit and the appropriate notice. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered.
5. **Threat to Health or Safety:** When a serious threat of physical violence against an identifiable victim is in known or reasonably suspected, efforts to communicate that information to the potential victim and the police must be issued.
6. **Medical Disability:** When a medical disability form is requested to e completed, this will be done with the client present.

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If you request to communicate by email, you release the physician from liability of lost and/or misplaced emails and emails that may be read by others. Please initial appropriate line:

_____ I **do** want to communicate with physician via email/text messages

_____ I **do not** want to communicate with physician via email or text messages

I have read the above statements and agree to treatment under these conditions:

Signed ________________________________ Date _______________________

Physician ______________________________ Date ________________________