NEW PATIENT INTAKE PACKET

Demographic and Insurance Information

IDENTIFYING INFORMATION

Patient's Name_____
Last First Middle Initial

Age_____ Date of Birth_____ Gender M ☐ F ☐ Social Security Number _____

Address_____

City_____ State_____ Zip_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email address_____ Marital Status: Single☐ Married ☐ Divorced ☐ Widowed ☐

Primary Care Physician_____ / Phone: _____

Referred by _____ / Phone: _____

Employment Status ☐Employed ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed

Emergency Contact_____Relationship_____

Emergency Contact Ph#_____

INSURANCE INFORMATION

Primary and Secondary Insurance

☐ Check if you are not using insurance

Primary Insurance_____ ID#_____

Group Number _____ Insurance Phone_____

Patient's relationship to Primary Insured: ☐self, ☐spouse, ☐child,☐other

Insured's Name _____ Insured's Date of Birth_____

Insured's Employer _____

Secondary Insurance_____ ID#_____

Group Number _____ Insurance Phone_____

Nevin Arora MD
Diplomate, American. Board of Psychiatry and Neurology, Board-Certified in Sleep Medicine

LUCIDITY
SLEEP PSYCHIATRY

Kristen LaMarca PhD
Clinical Psychologist PSY26819
Diplomate, Behavioral Sleep Medicine

Phone: (760) 650-2290
Fax: (760) 400-3026
www.luciditysleeppsych.com

OFFICE POLICIES AND INFORMED CONSENT

The following has been prepared in order to facilitate our work together. Please read this document carefully and communicate any concerns so they may be addressed immediately.

Confidentiality

The law, professional ethics, and common sense require that information disclosed within sessions is confidential and may not be revealed to anyone without your written permission. There are, however, some exceptions to the rule where disclosure is required by law: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; where a patient presents a threat to safety or danger to self, to others, to property, or is gravely disabled, or when required by a court of law. When applicable, insurance Providers, other healthcare providers, and other third-party payers may be given information related to services rendered. More details are available upon request of our Notice of Privacy Practices.

Patient Portal: Registration and Online Scheduling

All scheduling is completed online using our portal "Patient Ally", which can be accessed through our website or at www.PatientAlly.com, in lieu of contacting us by phone. Your cooperation leaves us more available to tend to more important aspects of your care.

When registering, you will receive an email from Patient Ally with a link to the portal. Once you create an account, complete any paperwork under the "Documents tab". Call us if you have difficulty using Patient Ally.

Follow-up appointments will be confirmed within about 1 business day in the portal. Request to reschedule or cancel appointments through the messaging feature of the portal. For your convenience, you may receive optional appointment reminders through our automated system via text, email, or phone call. Note that visits scheduled through Patient Ally are visible in the Patient Ally portal, visits scheduled by phone or in-person are not visible in the portal. Therefore, you are responsible for marking your appointment times on your personal calendar. Please use Patient Ally to keep your information up to date, such as by messaging us changes to your home address, phone number, insurance, and emergency contact information as needed.

Contact Procedures

Phone/Patient Portal: For non-emergency matters, contact us by phone at (760) 650-2290 during business hours or through the online portal. We typically respond within 1-2 business days during normal business hours. Messages left after 5 pm on Fridays will be returned at the beginning of the next week. Please use the portal for routine scheduling in lieu of contacting us by phone if possible. If there is limited unscheduled telephone consultation of an urgent matter between normal sessions, and it is 10 minutes or less, then there will be no charge. However, please bring any concerns related to your treatment to your face-to-face appointments, which are not always ideal to address by phone or portal messaging. If you need to send us documents but are not using the portal, there is an alternative, secure file uploader on our website.

Telehealth/Virtual Appointments: Instructions for attending virtual appointments are listed on our website under the Telehealth FAQ. Please note the messaging feature of the telehealth application is only for communication with

your doctor during your visit or exchanging documents. Scheduling staff do not have access to this feature. If you need to cancel or reschedule, you must contact us through our ordinary phone/portal contact procedures.

Email/Text/Social Media: We primarily communicate with patients through our secure patient portal and by phone. We do not use standard email for patient care. Social media contact is discouraged. We may use text messaging for limited administrative purposes such as appointment scheduling and coordination. Text messaging is not a secure or encrypted form of communication and should not be used for clinical concerns or urgent matters. We will never sell your information. Always reserve issues of a clinical nature for your face-to-face sessions with your providers.

By providing us your mobile number, you agree to receive messages related to routine scheduling communications. Message frequency varies, and standard message and data rates may apply. You have the right to OPT-OUT receiving messages at any time. To OPT-OUT, reply "STOP" to any text message you receive from us. Reply HELP for assistance.

Emergency procedures: In case of an emergency, call 9-1-1 or go to the nearest emergency room. The San Diego County Access and Crisis line is available 24/7 by calling 1(888)724-7240.

Medication refills: Please request medication refills at a minimum of 5 business days in advance. Dr. Arora may require an in-office visit for medication refills, so please plan accordingly.

Payment for Services

Payments for services are due at the time the service is rendered or a charge is incurred. Charges may include co-insurance costs, balances not covered by insurance, and late cancellation or no-show fees. We accept check, cash, or credit/debit card. Our fees are periodically raised with reasonable advance notice. Please notify us if any problem arises during the course of our work together regarding your ability to make timely payments. If you have not remit payment for outstanding balances or set up a fee payment plan within 90 days of charges, your account may be sent, with reasonable notice to you, to a collection agency.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

All patients are required to keep a credit card on file in case you choose not to arrange for an alternative means of payment at the time a charge is incurred or in case you do not update us with your residential address for invoicing. Your cooperation with this matter leaves us more available to tend to more important aspects of your care. You may request a detailed statement of charges or payments at any time.

Your bank statement may include a charge that states luciditysleeppsych.com. If you mistakenly initiate an unauthorized chargeback request through your bank or the card processor, you will be charged the fee again, plus any fees acquired for the error, plus an additional $25 administrative fee. You are responsible for keeping your credit card up to date. We will inform you immediately if you miss a payment for a service. You then have 10 business days to re-submit payment for that service. Otherwise a late payment fee of $25 for each unpaid charge will be incurred. Checks returned for insufficient funds will be billed to you in addition to bank fees incurred, plus an extra $25 fee. If you use a personal check, please fill it out prior to session rather than during or after your appointment. Checks may be made out to Lucidity Sleep & Psychiatry.

____ By initialing here and signing this form, I, the patient (or the patient's representative), acknowledge that payment is due at the time a service is rendered or a charge is incurred. I authorize that my credit card on file may be charged if I do not arrange for alternative means of payment prior to incurring a charge. I acknowledge these charges may include fees for missed appointments or late cancellations.

____ By initialing here and signing this form, I, the patient (or the patient's representative), acknowledge that if I miss a payment at the time of incurring a charge, then I must arrange for an alternate method of payment within 10 business days of incurring that charge, otherwise I will incur an additional $25 fee for late payment. I acknowledge that this includes failure to update my credit card information in a timely manner when appropriate.

____ By initialing here and signing this form, I, the patient (or the patient's representative), acknowledge that if circumstances arise in which I am unable to make timely payments, I will notify my providers immediately to address the situation or discuss alternative payment options to help minimize disruption to my care.

Insurance Reimbursement

If you are using insurance, you must determine the details of your coverage (e.g. deductible, copay, etc.) prior to your visit. Patients who carry insurance with which we are not contracted should remember that professional services are rendered and charged to the patient and not to the insurance company. If you choose to use your out-of-network benefits this means that we will be paid in full, by you, at the time of services rendered. Upon request only, we can supply you with a statement to submit to your insurance company for reimbursement to you, the patient. The only exception to this means of claiming your out of network benefits is if we have agreed to other arrangements for billing your insurance. Remember, we are not in a position to guarantee payment from your insurance company, and you are responsible for costs not covered.

Cancellation Policy

Since the scheduling of an appointment involves the reservation of time held specifically for you, a minimum of 24 business hours notice is required to cancel an appointment (If your appointment is on a Monday, you have until Friday at 6:00pm to cancel). **If you fail to cancel in advance of 24 business hours prior to your appointment, we cannot use this time for other patients and you will be billed up to the entire cost of the missed appointment.** In the event that a late cancellation is due to circumstances, which we both define as an emergency, a fee may not be charged. However, if you fail to inform us you will miss your appointment (no-show/no-call) even in the case of an emergency, you will still incur a late cancellation fee unless extreme circumstances prevented you from contacting us to cancel it.

If you are unable to make your appointment, please use Patient Ally to cancel online to allow us to accommodate our schedules. You may also call to cancel your appointment during normal business hours or leave a voicemail.

___ By initialing here and signing this form, I, the patient (or the patient's representative) acknowledge that I have read and agree with the cancellation policy as outlined above.

Records

We use a secure, encrypted electronic health records (EHR) system, Office Ally, to keep records of our sessions and submit insurance claims. You have the right to receive a summary of your records at any time. If you request the release of your information to other agencies or person(s), you will need to sign a written release of information form (these should be renewed at least once per year). You will be informed at the time of your request whether or not it is believed that releasing that information to that agency or person(s) might be harmful to you in any way. If a third party makes a request for your records and we have your permission to do so, we may offer a summary of your record of treatment, versus detailed consultation notes. Please note that HIPAA regulations permits providers to disclose to other health providers any protected health information in the medical record about an individual for treatment, case management, and coordination of care, and with few exceptions, treats mental health information the same as other health information. Requests for paper copies of records, instead of a summary, will incur a cost of $0.25/page plus any mailing or clerical costs. You may also incur a fee to compensate for any time required to review records prior to their release prorated at the clinician's full hourly rate rounded up to the nearest 15 minutes. If you request paperwork to be completed for you or a written letter, the cost incurred will be at the clinician's usual hourly rate rounded up the nearest 15 minutes.

Length of Treatment

You have a right to discontinue our work at any time and your only obligation at the point of termination is that of a financial nature for services already rendered and not yet paid in full. Also, please note that all patients of Dr. LaMarca are required to be seen at least once every 30 days in order to remain active under her care. If you are not seen within 30 days, and you and Dr. LaMarca have not clearly agreed to keep your case open, your case will be closed and you will be provided with referrals, if desired. Dr. Arora may require patients receiving psychiatric medications to be seen at least once every 120 days in order to remain active under his care. If your case is closed, you will need to complete the intake process again in order to re-establish your care.

Nurse Practitioner Services

Our practice may include care provided by a Nurse Practitioner (NP) who is licensed in the State of California. The NP may conduct medical evaluations, provide diagnoses, develop and manage treatment plans, prescribe medications when clinically indicated, and coordinate care with other healthcare providers. The NP practices in collaboration with the supervising physician, Nevin Arora, MD, in accordance with California law. You have the right to request to see the supervising physician at any time to discuss any aspect of your care.

____ By initialing here, I, the patient (or the patient's representative) acknowledge that I have read and understand that services in this practice may be provided by a Nurse Practitioner working in collaboration with the supervising physician, and I consent to evaluation and treatment by the Nurse Practitioner as part of my care, when clinically appropriate.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE ABOVE AND AGREE TO ABIDE BY THESE CONDITIONS:

_____

Print Name Signature of Patient/Patient's Legal Representative Date

This form was last on updated 02/19/2026

Intake Questionnaire

In order to make the best use of your appointment time, please complete this form prior to your initial appointment.

What is your name? (Who filled in this form?)_____

What is your relationship to the patient? ☐ Self ☐ Other:_____

Please state briefly the reason for making an appointment:

_____

_____

(Y= yes N=no DK= don't know)

On weekdays, when do you usually go to bed? _____ and wake up? _____
During the weekend, when do you usually go to bed? _____ and wake up? _____

How long does it take you to fall asleep at night? (Guess is OK) _____
Do you have any frequent awakenings during sleep? **Y N** How often? _____
Are awakenings related to needing to use restroom? **Y N**
Have you ever had a sleep study before? **Y N DK**
Do you snore? **Y N** Please rate from 0-10 the loudness of snoring (0-None, 10-Loud): _____
Have you been informed that you stop breathing or "gasp" while asleep? **Y N DK**
Do you wake up with a headache in the morning at least once a week? **Y N DK**
Have you had uncomfortable sensations in your legs worsened with prolonged rest or during the evening hours and relieved by movement? **Y N DK**
Do you kick your legs while asleep? **Y N DK**
Have you experienced sudden muscle weakness (e.g. legs, neck) after laughing or strong emotion? **Y N DK**
Have you awoken from sleep able to look around but unable to move or speak for a short time? **Y N DK**
Have you ever seen images, heard sounds, or felt something that was not present when drowsy or upon awakening from sleep? **Y N DK**
Please indicate if any of the following behaviors occur during your sleep (please check all that apply): ☐None apply ☐Sleepwalking ☐Sleep talking/shouting/swearing ☐Frequent nightmares ☐Bedwetting ☐Body jerking ☐Nocturnal cough ☐Dry mouth ☐Heartburn ☐Excessive sweating ☐Awakened with heart palpitations ☐Teeth grinding
How many caffeinated beverages do you drink on a typical day? _____
Do you use recreational drugs? **Y N** If so, which ones and how often? _____
How many alcoholic beverages do you consume in an average week? _____
Do you use tobacco? _____ How much? _____

Surgical/Medical history **Psychiatric history**

☐ Tonsillectomy	☐ High blood pressure	☐ Suicidal thoughts
☐ Deviated nasal septum surgery	☐ Atrial fib/Cardiac arrhythmias	☐ Thoughts of harming others
☐ Orthodontia/Braces	☐ Congestive heart failure	☐ Inpatient hospitalization
☐ Sinus surgery	☐ GERD/Heartburn	☐ Emergency Room visit
☐ Surgery for sleep apnea/UPPP	☐ Diabetes mellitus	☐ Schizophrenia
☐ Coronary artery bypass	☐ Hypothyroidism	☐ Bipolar disorder
☐ Cardiac angioplasty/stents	☐ High cholesterol	☐ Depressive disorder

☐ Pacemaker / AICD implantation	☐ Allergic rhinitis	☐ Anxiety disorder
☐ Neck surgery	☐ COPD	☐ Alcohol/drug dependence
☐ Back surgery	☐ Asthma	☐ Attention deficit-hyperactivity disorder
☐ Stroke/TIA	☐ Anemia	☐ Eating Disorder
☐ Alzheimer's/Other dementia	☐ Fibromyalgia	☐ None
☐ Seizure disorder	☐ Migraine headache	☐ Other pertinent history (list here)
☐ Parkinson's disease	☐ None	
☐ Other pertinent history (list here)		

Height: _____ **Weight:** _____ **Neck Circumference:** _____

Family Sleep and Psychiatric History: Place an "X" next to the relevant answer(s)

	Sleep apnea	**Narcolepsy**	**Insomnia**	**Restless Leg Syndrome**	**Depression**	**Anxiety**	**Substance/Alcohol Dependence**	**Unknown/ Other (List here)**
Father								
Mother								
Sister								
Brother								
Grandparents								
Children								

Please list medications and dosages, including sleep aids and supplements, that you take here (or provide list):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list allergies or adverse reactions to medications here:

_____

Briefly describe what you do for a living and what you like and don't like about it.

_____

_____

Highest level of education so far?
☐ Grade school ☐ Some high school ☐ High School ☐ Some college ☐ Some technical school ☐ Technical school diploma ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctoral degree

Do you have children? Y N If yes, how many and what age? _____

List anything else you would like your doctor to know about you.

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would never dose
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. theater, or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting, talking with someone	_____
Sitting quietly after a lunch without alcohol	_____

In a car, while stopped a few minutes in traffic _____

Fatigue Severity Scale (FSS) of Sleep Disorders

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.

- It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire

During the past week, I have found that:	**Disagree <--------> Agree**						
My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
Exercise brings on my fatigue.	1	2	3	4	5	6	7
I am easily fatigued.	1	2	3	4	5	6	7
Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
My fatigue prevents sustained	1	2	3	4	5	6	7

physical functioning.							
Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
	Total Score:						

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Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	**None**	**Mild**	**Moderate**	**Severe**	**Very Severe**
Difficulty falling Asleep	**0**	**1**	**2**	**3**	**4**
Difficulty staying Asleep	**0**	**1**	**2**	**3**	**4**
Problems waking up too early	**0**	**1**	**2**	**3**	**4**

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all	A little	Somewhat	Much	Very Much

0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all	A little	Somewhat	Much	Very Much
0	1	2	3	4

7. What extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all	A little	Somewhat	Much	Very Much
0	1	2	3	4

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