



**Lina Shuhaibar, M.D.**

Diplomate, The American Board of  
Psychiatry and Neurology

Child, Adolescent and Adult Psychiatry

1041 West Badillo, Suite 103  
Covina, CA 91722

Phone: (626) 339-0288  
Fax: (626) 339-2248

www.LinaShuhaibarMD.com

**PATIENT PERSONAL INFORMATION**

MARITAL STATUS \_\_\_\_\_ GENDER \_\_\_\_\_ AGE \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WK \_\_\_\_\_ CELL \_\_\_\_\_

SUBSCRIBER'S EMPLOYER \_\_\_\_\_

EMPLOYER & ADDRESS \_\_\_\_\_

PRIMARY INSURANCE CO \_\_\_\_\_ SECONDARY INS  YES  NO

NAME OF OTHER PROVIDERS WHO CARE FOR YOU AND THEIR PHONE NUMBER(S):

1 \_\_\_\_\_ TEL# \_\_\_\_\_ 2 \_\_\_\_\_ TEL# \_\_\_\_\_

PLEASE PROVIDE THE NAME & PHONE # TO CONTACT IN CASE OF AN EMERGENCY:

NAME \_\_\_\_\_ TEL# \_\_\_\_\_ RELATION \_\_\_\_\_

**PLEASE LIST ANY MEDICAL CONDITIONS THAT YOU SUFFER FROM SUCH AS HIGH BLOOD PRESSURE, DIABETES, HEPATITIS, ASTHMA, OR ANY OTHER CONDITION THAT DR. SHUHAIBAR SHOULD BE AWARE OF, INCLUDING MAJOR HOSPITALIZATIONS, ALLERGIES TO MEDS, & PREVIOUS PSYCHOTHERAPY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRESENTING PROBLEM: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT NAME \_\_\_\_\_

DOB \_\_\_\_\_

**CONSENT FOR TREATMENT**

I authorize and request that Lina Shuhaibar, M.D. provide psychiatric and/or psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my treatment are recommended. I understand that the purpose of these procedures will be explained to me upon request and are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my doctor can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my doctor and me. I understand that all communication between my provider and me is privileged and confidential and no information will be released without my written or verbal consent.

**PATIENT INITIALS** \_\_\_\_\_

**GENERAL CONSENT FOR CHILD OR DEPENDENT TREATMENT**

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

**PARENT/GUARDIAN INITIALS** \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Patient Representative Name – Print

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**RELEASE OF INFORMATION TO HEALTH PLAN**

I authorize the release of information for claims, certification/case management/quality improvement, and other purposes related to the benefits of my health plan.

**PATIENT INITIALS** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

Employee Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Address (if different from patient's) \_\_\_\_\_

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment to be made directly to the provider of service: Lina Shuhaibar, M.D.**

\_\_\_\_\_  
Insured Signature

\_\_\_\_\_  
Date

**I acknowledge that I have read the Notice of Privacy Practices for Lina Shuhaibar, M.D. Psychiatrist and that I have also read and understand the Office Policies.**

I wish to have a copy of this notice today.

I do not wish to receive a copy of this notice at this time. I may request a copy of this notice at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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