Advanced Psychiatry Associates
Hisham Soliman, MD, MPH

INSURANCE RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS: I authorize Advanced Psychiatry Associates to release to my Medicare/Medicaid carrier or the Insurance carrier currently facilitating my coverage, any medical information needed for authorization or payment of this or related claims. Additionally, I authorize payments directly to this office for the mental health benefits that I receive. I understand that I am responsible for all pre-authorizations required by my insurance. Furthermore, I understand that I am financially responsible for all charges incurred by rendered services whether paid by my insurance company or not.

FINANCIAL AGREEMENT

Pre-Authorization for Mental Health Services: Most insurance companies require pre-authorization for mental health services. We strongly encourage you to contact your insurance company to inquire about any pre-authorization requirements. You may also want to obtain information regarding your mental health benefits. Most often, health insurance benefits for mental health are different from the benefits for general healthcare. We do not administer your plan so we cannot provide details as to how your coverage is to be applied. Please contact our billing department should you have any questions regarding the information provided by your insurance.

Payment of Services: Patients are required to pay all co-pays, co-insurance, cost share and balances on account at the time of service. If receiving telehealth services, all payments are collected the day prior to the appointment unless this date falls on a weekend at which point payment will be collected the Friday preceding the appointment. If payment cannot be made, a statement will be mailed and payable within 10 days of receipt. If payment cannot be made when due, you must contact our Billing Department to set up a payment plan. After 90 days, if no payment has been received, necessary collection proceedings will begin. It is important that you notify us of any changes of address promptly as undeliverable statements are turned over to collections immediately.

Insurance: If you have insurance, **Advanced Psychiatry Associates** will complete and mail insurance claims on your behalf. However, you are responsible for all pre-authorization requirements, insurance claim follow up, and all charges not covered by your insurance. In addition to this you as the policy holder are responsible for notifying the office of any coverage changes. This includes secondary insurance plans. We do not administer your insurance plan. It is at your discretion to contact your insurance company to gather a full understanding of your benefits and how they are applied. Failure to update the office of changes in insurance information can cause a delay in claim submission which can result in a patient balance and responsibility. Claims are subject to 'timely filing requirements' which means that insurance providers will refuse payment if claims are not submitted in time and you as the patient may incur a bill. Please contact your insurance to inquire about the portion of charges they will pay, prior to receiving your first explanation of benefits. It is often the case that insurance benefits for mental health are different from primary care. This includes lab services. If you do not receive an explanation of benefits from your insurance company within 30 days of your date of service, please follow up with your insurance on the delayed claim. After you have spoken with your insurance company, please call the billing department at 916-963-7200, to inform us of the status on the claim. **Advanced Psychiatry Associates** reserves the right to charge the patient the full amount of the visit if there is no response from the insurance company within 45 days of the date of submission. If you have any questions regarding your account or the filing of your insurance claims, please call us at 916-351-9400. We will be happy to assist you.

Appointment No-Show Fee & Grace Periods: By signing this form I acknowledge that I have been informed that this office requires **48- business hour** prior notice on all appointment cancellations. This means that you must submit a request to cancel or reschedule by the Thursday before your Monday appointment if you would like to avoid the fee. Advanced Psychiatry Associates provides a courtesy grace period if you are running late; grace period includes 15 minutes for any in person therapy appointment, and 10 minutes for any in person practitioner appointment. Telehealth appointments will allow a grace period of 5 minutes. If you do not check in for your appointment within that grace period you will have to reschedule, and a fee will be applied to your account. I have been advised that there will be a "no-show" fee of **$150** for the first missed appointment. Established patients will incur a **$100** Fee for any appointments that are not canceled 48 business hours prior to the appointment date, or if patient does not attend the appointment.

As a courtesy we offer text, email, and voice reminders 48 and 24 hours before every appointment

Work Comp. Patients are not personally subject to fees associated with last-minute cancellations; however, the charge will be forwarded onto the company who carries your claim.

Telehealth Notice & Disclosure:
If you are receiving therapy or medication management services via telehealth, please note that you are responsible for ensuring that all of your contact information is correct and current and that you are present and available at the time of the appointment. This office will allow a 5-minute grace period for telehealth visits. Failure to connect within this grace period will result in a missed appointment fee and you will need to reschedule. In the event you have not received any outreach within the first 3 minutes of your appointment time please reach out to the office immediately to be transferred to your provider. 916-351-9400.

Private Pay:

- $250.00 for the Initial Visit, and $150.00 for follow-up visit when meeting with MD or Nurse Practitioner
- $150.00 for the Initial Visit, and $100.00 for follow-up visit when meeting with Therapist.
- $150.00 for all lab services *administered by Advanced Psychiatry Associates
- TMS (Transcranial Magnetic Stimulation) Therapy: $250.00 first treatment, $150.00 follow-up sessions.

Acceptable forms of payment:

- **Credit Card**
- **HSA's**
- **Money Order**
- **Check**

*****WE DO NOT ACCEPT CASH. BOUNCED CHECKS WILL INCUR A $30.00 FEE*****

Paperwork: We charge for the completion and dispensing of Paperwork, Letters, and Medical Records; this includes responding to Disability, EDD, or Social Security forms. **Completion of any document request does not begin until the fee is paid in full**. Any patient on a timeline is advised to pay fees as soon as they become aware of timeframe requirements as there can be a 7–14-day turnaround for completion.
Fees range between $50.00 and $300.00, depending on the request. All fees are non-negotiable, non-refundable and will only be collected upon approval of document request.

- Before document service requests can be considered for Completion; Patients are required to have both the Initial Intake done and two follow-up appointments. This includes disability, social security, and everything in between.
- Please note that this office is not legally or financially responsible for any delay or loss of payments. Disability has an appeals process. In the event you let your claim laps it is your responsibility to resolve and correct.

Medical records will be a $15.00 flat fee upon approval, in addition to a $35.00 dispensing fee.

Work Comp. Patients cannot be directly billed for paperwork; however, their insurance carrier will be invoiced.

I understand and agree to abide by the above Insurance Release of Information/Assignment of Benefits and the Financial Agreement.

Signature of Patient/Guarantor: X _____ Date: _____

Insurance Name: _____

Member ID Number: _____

Advanced Psychiatry Associates

AUTHORIZATION FOR MEDICAL TREATMENT, STATEMENT OF RESPONSIBILITY, ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES, PATIENT RIGHTS & RESPONSIBILITIES, and MAGELLAN MEMBER RIGHTS & RESPONSIBILITIES

Patient's Name: _____ Patient's Date of Birth:_____

Authorization for Medical Treatment: I authorize the physician(s), psychologist(s), therapists(s), their assistants and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Advanced Psychiatry Associates. ("Facility). This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests, and the use of prescription medication. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or therapist(s) whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating physician(s) and the Facility & will follow the instructions of my physician(s) in the provision of said care.

Statement of Responsibility: I understand that I am financially responsible to the Facility(s) as the patient, parent, guardian, and conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, or out-of-pocket expenses.

Notice of Privacy Practices: I have been given the opportunity to review the Facility's Notice of Privacy Practices for Protected Health Information. I understand that the Facility has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy at the Facility's office policies during normal business hours.

Patient Rights & Responsibilities: I have been given the opportunity to review the Facility's Patient Rights & Responsibilities. I understand that the Facility has the right to change Patient Rights & Responsibilities at any time, and that I may obtain a current copy at the Facility's office policies during normal business hours.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient/Guardian Signature: X _____

Printed Name: _____

Date: _____

Advanced Psychiatry Associates

IMPORTANT PATIENT INFORMATION

The providers and staff of Advanced Psychiatry Associates feel that we can better serve your health care needs if you are familiar with the following policies and procedures:

Office Hours and Appointments: The office is open Monday through Friday from 9 a.m. to 6 p.m. The providers are always available on an emergent basis via email and in chat box within our website during regular business hours however, for best results it is advised that you contact our call center for immediate assistance at 916-351-9400. Follow-up appointments should be made when leaving the office. However, appointments may also be scheduled by calling 916-351-9400. If attempting an emergency walk-in appointment, due to the unscheduled nature that emergencies impose, occasional delays may occur. We hope that you will understand that these delays are unavoidable, and we will do everything in our capacity to ensure your needs are met.

Cancellations: If you are unable to keep your appointment, please cancel at least **48 business hours** prior to your appointment time and we will be happy to reschedule your visit. (IE; Monday appointments must by canceled Thursday the week prior to avoid a fee)

Paperwork: We charge for the completion and dispensing of Paperwork, Letters, and Medical Records; this includes responding to Disability, EDD, or Social Security forms. We are not legally or financially responsible for any loss of income or benefits due to delays with your claims. EDD, Disability, and social security have appeals processes which you have the ability to use in the event of any delay to your claim. You are responsible for ensuring that you take the necessary steps to ensure that your claim is active and current at all times.

- **Requests for document services can be submitted by fax to 916-351-9449 or email to** documentservices@advancedpsychiatryassociates.com
- **Completion of any document request does not begin until you have completed three appointments with the clinic.**
- **Completion of any document request does not begin unless the provider agrees to the service request.**
- **Completion of any document request does not begin until the fee is paid in full**.

Any patient on a timeline is advised to pay fees as soon as they become aware of timeframe requirements as there can be a 7–14-day turnaround for completion.

Fees range between $50.00 and $300.00, depending on the request. All fees are non-negotiable, non-refundable and will only be collected upon approval of document request.

- **Medical records will be a $15.00 flat fee upon approval, in addition to a $35.00 dispensing fee.**
- **Record requests can be submitted by fax to 916-351-9449 or email to** Records@advancedpsychiatryassociates.com

PrescriptionRefill Requests: It is important that we closely monitor your medication and therefore, we require that you schedule an appointment prior to requesting a prescription refill. For refills of medication that require a written prescription, please call our office at 916-351-9400 and select the option for medication refill. For all other medications, please call your pharmacy to request a refill and we will respond to your pharmacy as soon as possible. Please note that most medications require an office visit prior to refill being issued or insurance authorization; and this process can take 3-4days. If you miss your appointment, no refills will be given.

TelephoneCalls: You may call our office to ask a question, report a medication side effect, or the worsening of a condition. We will make every effort to return your call as soon as possible in the event your call goes unanswered. Most often, calls will be returned promptly. Any voicemails left after hours will be returned the next business day. You may also use http://www.advancedpsychiatryassociates.com to communicate with staff during regular business hours. If you encounter a true medical emergency; call 911 or head to the nearest emergency room/ urgent care.

Partial Invalidity: I understand and agree that if any provision of this agreement is held by a court of competent authority to be invalid, void, or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

Termination Policy: I understand that this office has the right to discontinue services at any time without limitations, for any reason. Reasons may include failure to attend a scheduled appointment, failure to communicate or cooperate with the physician and staff, and/ or failure to comply with prescribed treatment requirements. I am aware that my treatment is “at will” and I reserve the right to terminate or refuse treatment (including medication) at any time. While undergoing any treatment, I agree to immediately inform Advanced Psychiatry Associates of anything pertaining to or affecting my treatment in order to ensure that I receive the highest level of care.

Release of Information: By signing below I consent to the release and exchange of my medical information between Advanced Psychiatry Associates and my primary treating physician, my referring physician, or any other entity necessary in order to recoup payment from my insurance provider and to ensure that I am being provided the utmost quality of care.

Patient/Guardian Signature: X _____

Printed Name: _____ **Date:** _____

Advanced Psychiatry Associates
Hisham Soliman, MD, MPH

PATIENT INFORMATION

Your health is of utmost importance to us. To assist in your evaluation, please fill out this form as accurately as possible. All information will be treated confidentially.

Last Name:_____First Name:_____MI: _____

Address:_____City:_____State:_____Zip: _____

Home Phone:_____-_____- _____ Cellular:_____-_____- _____ Work Phone:_____-_____- _____

May we contact you at home?_____Yes,_____No May we contact you at work?_____Yes_____No

Email address: _____

Date of Birth:_____-_____-_____ SSN:_____-_____-_____ Sex: Male_____Female_____

Marital Status:_____Married_____Single_____Widowed_____Divorced_____Separated

Preferred Language: _____

RACE:

_____Caucasian or white
_____Black or African American
_____Asian
_____Native Hawaiian or other Pacific Islander
_____American Indian or Alaska Native
_____Other
_____Not reported or refused

_____Hispanic or Latino
_____Not Hispanic or Latino

Is this visit due to an accident of any kind?_____Yes_____No

Spouse Name:_____Spouse SSN:_____-_____-_____

Parent/Guardian Name:_____Parent/Guardian Number:_____

PERSON FINANCIALLY RESPONSIBLE: Same as patient check here: _____

Name:_____Relationship to Patient: _____

Address:_____City:_____State:_____Zip: _____

SSN:_____-_____-_____DOB:_____Employer: _____

Home Phone:_____-_____-_____Work Phone:_____-_____-_____Cell Phone:_____-_____- _____

Are you covered by an employer's health insurance plan or that of a family member? _____

INSURANCE INFORMATION: Does your insurance provide benefits for mental health services? _____

Does your insurance require pre-authorization for mental health services?_____Do you have authorization? _____

Does your insurance have a maximum number of visits per year?_____If so, how many? _____

PRIMARY INSURANCE:

Primary Insurance Company:_____Phone Number:_____-_____- _____

Policy Holder's Name:_____DOB:_____Relationship to Patient: _____

Policy Number:_____Group Number: _____

Policy Holder's Employer:_____Co-Pay Amount: _____

SECONDARY INSURANCE:

Secondary Insurance Company:_____Phone Number:_____-_____- _____

Policy Holder's Name:_____DOB:_____Relationship to Patient: _____

Policy Number:_____Group Number:_____Policy

Holder's Employer:_____Co-Pay Amount: _____

CONFIDENTIAL PATIENT INFORMATION

Your health is of utmost importance to us. To assist in your evaluation, please fill out this form as accurately as possible. All information will be treated confidentially.

Date: _____

Name:_____**DOB:** _____

Primary Care Provider:_____**City/State:** _____

Please explain the reason for your visit and how we can help:

_____

_____

_____

_____

_____

IF APPLICABLE, EDUCATION AND SCHOOL HISTORY:

Patient's School:_____**Patient's Grade in School**: _____

REFERRAL INFORMATION: Whom may we thank for referring you to our office?

_____**Referring Doctor or another medical provider:** _____

_____**Therapist or counseling center:** _____

_____**Hospital, nursing home, or other facility:** _____

_____**Friend or Family Member:** _____

_____**Online or website:** _____

May we provide your Primary Care Provider and Referring Provider with your individual health information to assist in the coordination of your health care?_____**Yes**_____**No**

Patient/Guardian Signature: X_____

Date: _____

ADVANCED PSYCHIATRY ASSOCIATES

Patient Rights and Responsibilities Statement

Patients have the right to:

Be treated with dignity and respect.

Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.

Have their treatment and other member information kept confidential. Only where permitted by law may records be released without member's permission.

Easily access care in a timely fashion.

Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
Share in developing their plan of care.

Receive information in a language they can understand.

Receive a clear explanation of their condition and treatment options.

Receive information about clinical guidelines used in providing and managing their care.
Ask their provider about their work history and training.

Give input on the patient's Rights and Responsibilities policy.

Know about advocacy and community groups and prevention services.

If asked, your insurance company may act on the member's behalf as an advocate. Freely

file a complaint or appeal and to learn to do so.

Know of their rights and responsibilities in the treatment process. Request
certain preferences in a provider from your insurance company.

Receive a copy of HIPAA Disclosures. I have received, read, and understand this disclosure.

Receive information about the benefits, risks, and the side effects of all prescribed medications. Patients can ask to have such information reviewed at any time.

If you have any questions about your Rights and Responsibilities, you may contact Dr. Hisham Soliman, MD, MPH at 916-351-9400 or email him at hisham.solimanmd@Advancedpsychiatryassociates.com

PSYCHIATRIC EVALUATION QUESTIONAIRE

Name:_____ **SSN:**_____-_____-_____ **Age:**_____

Reason for visiting the Psychiatry Office today:

_____

_____

_____

_____

How did you get to the clinic today? _____

Have you ever been a patient in a Psychiatric Hospital/Mental Health Clinic?_____If yes, please give the names of the hospitals and the dates:

_____

_____

Have you ever been treated by a Psychiatrist/Psychologist?_____If yes, please give their names and dates of when you were seen:

_____

_____

_____

List any medications you are currently taking (dosages and how often you take them):

_____

_____

_____

Do you have any allergies to medications?

_____

_____

If you have experienced any of the symptoms below:

Depression	_____YES	_____NO
Anxiety	_____YES	_____NO
Panic Attacks	_____YES	_____NO
Mood Swings	_____YES	_____NO
Anger Problems	_____YES	_____NO
Violent Outbursts	_____YES	_____NO
Paranoia	_____YES	_____NO

Have you ever tried to harm yourself?

_____

_____

_____

_____

Is there a history of mental illness in your family?_____If yes, please list who and what their diagnosis is: _____

_____

_____

_____

Where were you born? _____

How many siblings do you have? _____

Have you ever been married? If so, how many times? _____

If you have children, please list how many: _____

How many years of education do you have? _____

Do you have any college or specialized training?_____If yes, what type?

_____

What was your most recent job? _____

How long did you work there?_____Why did you leave this job?_____

Do you drink alcohol?_____Do you use street drugs?_____If yes, what is the type and frequency of use?_____

Please list and describe any other health problems:

_____

_____

_____

_____

_____

_____

Where do you live currently? _____

Who else lives with you? _____

Where do you get your financial support? _____

Please describe how you spend a typical day. For example:

- What time do you get up?
- What time do you go to bed?
- What do you cook for yourself or others throughout the day?
- Do you visit friends?
- Do you work?
- Do you do household chores?
- Run errands, shop, bathe yourself, dress yourself?
- Are there any hobbies you enjoy?

After filling this form out please sign in the fields marked signature. If you filled this form out on your computer please print and sign and bring with you to your first appointment.

Patient/Guardian Signature: _____ **Date:** _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

GAD-7 Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✓" to indicate your answer"*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Column totals:	___ +	___ +	___ +	___

= *Total Score* _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

GAD-7 total score for the seven items ranges from 0 to 21. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively.

Scores represent: 0-5 mild 6-10 moderate 11-15 moderately severe anxiety 15-21 severe anxiety.

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PATIENT MEDICATION CONSENT FORM

1. Medication: the nature and purpose of each medication I am receiving for Psychiatric illness has been explained to me.
2. Other Treatment Modalities: The responsibilities of taking the medication as instructed have been explained to me. Problems and benefits and other forms have been reviewed by me.
3. Side Effects: The possible side effects of each medication I am receiving has been explained to me.
4. Psychopharmacology: By signing this consent form patient has acknowledged that they have been informed of side effects, benefits of taking the medication(s) and advised of the importance of healthy lifestyle to avoid adverse reactions or interactions with other medications. Patient has been informed of effects of overdose or noncompliance with medication(s). Patient agrees with management plan and consents for the medication(s).
5. Controlled Substance: medication requires frequent monitoring by having a follow up appointment monthly to obtain refills. Informed & discussed that controlled substances can lead to dependence and addiction. Was discussed these medications needs to be stored in a safe place out of reach of children. It is best if they are kept in a locked container to prevent theft/access by children. Random Urine drug screen (UDS) will be required for ongoing medication management. Once requested you will have 7 days to complete this request. If any discrepancy is noted on UDS or on CURES drug monitoring report it is grounds for termination from Advanced Psychiatry Associates. If our office is dispensing you SCHEDULE II medication, it is a violation of this contract to seek additional controlled substances from outside providers within that prescription timeframe. Any violation of our controlled substance policy is grounds for termination for Advanced Psychiatry Associates.

I understand that in general I may be weaned off my medication or my drug therapy may be terminated at the discretion of my physician if any of the following occur:

- **It is the opinion of my physician that controlled substances are not very effective for my pain and or my functional activity is not approved,**
- **I misuse the medication,**
- **I develop a rapid tolerance or loss of effectiveness from my treatment,**
- **I develop side effects that are significant and detrimental to me,**
- **I obtain controlled substances from sources other than my psychiatrist without informing them,**
- **I am arrested and/or convicted for a controlled or illicit drug violation including but not limited to drunk driving or driving while under the influence of a controlled substance,**
- **Any violation of this agreement.**

6. Tapering down and Titrating up Medications: Instructions have been discussed with the patient and the patient has been advised to follow recommendations.

I have been given the above information. I understand that any changes in medication will be discussed with me and that medications will be periodically reviewed between the prescribing clinician and myself. I understand that I am not required to take anything that I do not agree with. However, if filling and taking medication it must be done as directed by the provider to avoid side effects or injury.

Patient/Guardian Signature: _____ Date: _____

Physician's signature: _____

Advanced Psychiatry Associates
Hisham Soliman, MD, MPH

Phone (916) 351-9400
Fax (916) 351-9449
www.advancedpsychiatryassociates.com

NOTICE TO THERAPY PATIENTS

Here at Advanced Psychiatry Associates, we want you to get the best care.

Advanced Psychiatry Associates strives to provide the highest quality treatment. If you received outstanding service or you are not satisfied with your treatment and care, please let us know.

Telephone number: (916) 351-9400
Mailing address: 2440 Professional Drive, Roseville, CA 95661

California Board of Behavioral Sciences Required Notice:

The Board of Behavioral Sciences receives and responds to complaints regarding services provided by individuals licensed and registered by the board. If you have a complaint and are unsure if your practitioner is licensed or registered, please contact the Board of Behavioral Sciences at 916-574-7830 for assistance or utilize the board's online license verification feature by visiting www.bbs.ca.gov.