PATIENT INFORMATION

(*PLEASE PRINT*)

Date: _____

Patient Name:_____ M ( ) F ( )

Address:_____ Apt. #_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ SSN:_____

Home #:( )_____ Work #:( )_____ Cell #:( )_____

Name of Employer or School:_____

Marital Status: Single ( ) Married ( ) Widowed ( ) Divorced ( )

Appointment reminder are done via email & text messaging. By entering your phone number and/or email address, you agree that we may send you email/text notifications for your appointment(s).

Email Address: _____

Cell #: _____

Please indicate which mode of contact you prefer: ( ) Email ( ) Text Msg ( ) Both

In case of emergency contact: Name: _____

Telephone: _____ Relationship: _____

INSURED AND/OR RESPONSIBLE PARTY (if different from above)

Name:_____ M ( ) F ( )

Address:_____ Apt. #_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ SSN:_____

Home #:( )_____ Work #:( )_____ Cell #:( )_____

Relationship to Patient: Self ( ) Spouse ( ) Parent ( ) Other ( )

Name of Employer:_____

Please present your insurance card and photo id to the front office

PRIMARY CARE PHYSICIAN

Name: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone: ( )_____ Fax: ( )_____

CLIENT'S CONSENT TO TREATMENT

By signing below, you consent to treatment rendered by your physician/therapist. There are both risks and benefits to mental health treatment. Your physician/therapist will be happy to discuss these with you. You are free to review your treatment plan and if you disagree with any aspect of it, your physician/therapist will try to offer an acceptable alternative treatment plan. Should you refuse the recommended treatment, please understand that your physician/therapist may elect in withdraw his/her services, Also, by signing, this consent, you are agreeing to report any suicidal or homicidal feelings to your physician/therapist. You will call your physician/therapist should your suicidal or homicidal feelings intensify to the point that you feel unable to prevent yourself from acting on them. You understand that your physician/therapist may suggest you enter a hospital at that time for your own protection or for the protection of others. You may also give your physician permission to send a copy of your treatment plan to your primary care physician. This is entirely voluntary, but is requested by some insurance companies.

OFFICE HOURS: 11:00 - 6:00 p.m., Monday thru Friday.

APPOINTMENTS: Our office telephone number is **(602) 795-8698**. If you need to change or cancel your appointment, please give 48 hours prior notice. Your physician/therapist has reserved that time for you and **a full charge may be made if adequate notice is not given**. Your insurance will not pay for missed appointments.

ROUTINE DAYTIME TELEPHONE CALLS: All patients are encouraged to call if there is a problem. Please understand that your call will be returned at the earliest opportunity by either your physician/therapist or the office staff.

EMERGENCY OR AFTER-HOURS TELEPHONE CALLS: If you need to call after hours, you will reach our voice mail system. You will be prompted to indicate if the call is urgent. If this is the case, your physician/therapist will be paged. If you are unable to reach your physician and feel that you can't wait for him/her to return your call, contact your family physician, the nearest emergency room, or call 911.

FEES AND PAYMENTS: You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. **Please pay your co-pay or deductible at the time of service.** Fees will vary depending on the service provided. In circumstances of unusual financial hardship, your physician/therapist may be willing to negotiate a fee adjustment or payment installment plan. Payment can be made by cash, check, Visa, Mastercard and Discover. Monthly interest charges will be added to accounts with an outstanding balance over 90 days. If your account has not been paid for more than 120 days and arrangements for payment have not been agreed upon, your physician/therapist has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require him/her to disclose otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE: We will gladly bill your insurance for you. Unless obligated by contract with your insurance company, this is done as a courtesy for you. ***It is your responsibility to know your mental health benefits***. When we obtain benefits from your insurance, please note that it is only an estimate of benefits. The actual benefit will be determined at the time the claim is received. If your insurance company requires that you contact them to obtain prior authorization for services and you fail to do so, you are responsible for payment in full of any denied claims. You should also be aware that your contract with your health insurance company requires that information relevant to the services rendered also be provided to them. Your physician/therapist is often required to provide a clinical diagnosis. Sometimes he/she is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Medical Record. In such situations, he or she will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Your physician/therapist will provide you with a copy of any report submitted, if you request it. By signing this agreement, you agree that we can provide requested information to your carrier. If you have questions in regards to how a claim was paid by your insurance, please contact them directly. Should you receive payment directly from your insurance, please endorse the check and forward it to this office along with a copy of the Explanation of Benefits so that we may post it to the correct date of service.

PRESCRIPTIONS AND RENEWALS: All prescriptions and authorizations for renewals should be requested from the physician during your scheduled appointment, not by telephone unless an emergency.

LIMITS ON CONFIDENTIALITY : The law protects the privacy of all communications between a patient and his/her health care provider. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Your psychiatrist/therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The other professionals

are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Medical Record (which is called "PHI" in our Notice of Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without your physician/therapist's (or otherwise authorized) permission .
- We also have contracts with a number of insurance companies and an electronic billing service. As required by HIPAA, we have a formal business associate contract with this/these business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself/herself, your physician/therapist may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where your physician/therapist is permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services he or she provided you, such information is protected by the physician-patient law or other statute. We cannot provide any information without your or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, and we are providing services related to that claim, we must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which your physician/therapist is legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in this practice.

- If your physician/therapist has reason to believe that a child under 18 who he or she has examined is or has been the victim of sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that he or she file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, he or she may be required to provide additional information.
- If any physician/therapist has reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that he or she file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, he or she may be required to provide additional information.
- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and your physician/therapist believes that the patient has the intent and ability to carry out such threat, he or she must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, your physician/therapist will make every effort to fully discuss it with you before taking any action and will limit their disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PATIENT RIGHTS: HIPAA provides you with several new or expanded rights with regard to your Medical Record and disclosures of protected health information. These rights include requesting that your record be amended; requesting restrictions on what information from your Medical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about your physician's policies and procedures recorded in your records; and the right to a paper copy of this agreement, the Notice form, and any privacy policies and procedures. Your physician/therapist will be happy to discuss any of these rights with you.

I understand this agreement and hereby consent to treatment and agree to the policies as outlined above. I agree to the release of protected health information for the purposes of billing insurance or other payor. I have been provided with the Arizona privacy notice and have read and understand this notice. I understand that I may request and be provided with a written copy of this notice.

_____ Date: _____

Signature of Patient or Responsible Party

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I agree to allow the release of my Medical Record to my primary care physician _____.

(PCP Name)

_____ Date:_____

Signature of Patient or Responsible Party