Scottsdale
Mental Health & Wellness
INSTITUTE

PATIENT INFORMATION

Patient Name: _____ Nickname/Preferred Name: _____
First MI Last

Birthdate: ____/____/____ SS#: ____-____-____ Sex: ☐ F ☐ M

Street Address _____ City _____ State _____ Zip Code _____ P.O. Box _____

Primary Phone #: _____ Secondary Phone#: _____

Email Address: _____ Work Phone #: _____

Occupation: _____ Employer: _____

Spouse/Partner Name or Parent Name For Minor Patients (If applicable)

Name: _____ Relationship: _____
First MI Last

Primary Phone #: _____ Secondary Phone#: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Emergency Contact (If different than above)

Name: _____ Relationship: _____
First Last

Primary Phone #: _____ City/State: _____

Primary Insurance Info

Insurance Card Holder's Name (if different than patient): _____

Company: _____ Birthdate: ____/____/____

SS#: ____-____-____ Group #: _____ Policy #: _____

Secondary Insurance (if applicable)

Company: _____

SS#: ____-____-____ Group #: _____ Policy #: _____

Primary Phone #: _____ Secondary Phone #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Scottsdale Mental Health & Wellness Institute or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

Referral Source / Mental health history: please give a brief description of concerns/previous diagnosis

_____

_____

_____

_____

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CONSENT FOR TELEHEALTH SERVICES

What are Telehealth Services? Telehealth services are used when our patients and their respective physicians, psychiatrists or other clinical personnel (hereafter "Clinicians") cannot be physically together for mental health evaluation needs or the provision of individualized or group-level services. Telehealth services use video and audio technology to send both voice and visual images between you and the Clinicians.

How do Telehealth Services work? All patients participating in Telehealth delivery should use their reasonable best efforts to interface with Clinicians in a private setting using a two-way, interactive device with video capability (e.g. personal computers, tablets, smartphones or other personal devices with video capability). Treating Clinicians interfacing with patients will also utilize similar equipment in private settings when delivering care. Patients participating in group-level services should use their reasonable best efforts to maintain patient privacy for all participating patients and should ensure third parties are not able to overhear or view participating patient information.

Are Telehealth Services private and secure? The interactive electronic systems used comply with federal privacy and security law and/or as otherwise directed by Health and Human Services, Office of Civil Rights and other Federal oversight agencies.

However, when it comes to privacy and security with group-level services, it is the responsibility of each participating patient to ensure that while participating in the telepsychiatry services they ensure that no third parties are present or listening to the group-level session.

What happens if I choose not to consent to Telehealth Services? If you choose not to consent to Telehealth services, you will be provided with an onsite Clinician to provide you face-to face psychiatric services, subject to the Facility's capability to provide onsite psychiatric services. Telemedicine privileges shall include consulting, prescribing, rendering a diagnosis or otherwise providing clinical treatment to patients through the use of visual & audio technology.

My Rights and Responsibilities

- ☐ I understand that the laws that protect the privacy and confidentiality of medical information also apply to telehealth services.
- ☐ I understand that the technology used is encrypted to prevent unauthorized access to my private medical information or is otherwise consistent with guidance from Health and Human Services, Office of Civil Rights and other Federal oversight agencies.
- ☐ I understand that in some circumstances I may only be able to provide my verbal consent to the terms of this Consent and that verbal consent shall be documented by the Clinicians and/or the facility and shall be of the same force and effect as my written consent.
- ☐ I have the right to withhold or withdraw my consent to the use of telehealth services during the course of my care at any time. I understand that my withdrawal of consent will not affect my eligibility to receive future care or treatment. I further understand that declining telehealth services may result in delays or restrictions in accessing on-site care subject to facility capabilities.
- ☐ I understand that the Clinicians and/or facility have the right to withhold or withdraw this consent for the use of telehealth services during the course of my care at any time if it is determined I am not able to reasonably participate in telehealth delivery.
- ☐ I understand that in the event I do not make my reasonable best efforts to ensure the privacy of other participating patients in group-level services, the Clinicians and/or facility have the right to withhold or withdraw the availability of Telehealth services to me.
- ☐ I understand that all rules and regulations which apply to the practice of medicine in the state of Arizona also apply to telehealth services.
- ☐ I understand I may not have any face to face contact with my Clinicians, except for my telehealth services visits.
- ☐ Telehealth services will not be recorded.
- ☐ The Clinicians will inform me if any other person can hear or see any part of our telehealth services session before the session begins.

Patient Consent To The Use of Telehealth Services

- ☐ I consent to telehealth services and I have read and understand the information provided above regarding telehealth services. I have had the opportunity to ask questions about this information and questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth services in my psychiatric care and authorize use of telemedicine in the course of my diagnosis and treatment.

Name _____ Signature _____ Date _____

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MEDICATION CONSENT

My physician will discuss:

1. The nature of my mental condition that may include the following: (please check each one you feel represents a concern of yours)

☐ Depression	☐ Sadness	☐ Irritability	☐ Anxiety	☐ Excessive worry
☐ Feeling nervous	☐ Sleeping problems	☐ Lack of interest	☐ Lack of pleasure	☐ Thoughts of suicide
☐ Feelings of guilt	☐ Low energy	☐ Difficulty thinking, concentrating, remembering		
☐ Labile moods	☐ Mood swings	☐ Paranoid thinking	☐ Delusionsal thinking	☐ Hallucinations

2. The reasons that my physician has for prescribing the medication, including the likelihood of my condition improving or not improving without the medicine. You should start to notice some benefits of this medication within 1 to 2 weeks after initiation of therapy. If you have experienced no benefit after one month of treatment at the prescribed dose, contact your doctor. Maximum benefits usually seen after 6 weeks or more. This medicine must be taken for several weeks before its full benefits are felt. Do not stop taking the medication suddenly because you may experience dizziness, headache, nausea, sweating, increased heart rate or anxiety. If you are pregnant or planning to become pregnant contact your prescriber immediately.
3. Reasonable alternative treatments available for my condition, including, but not limited to exercise (as allowed by your primary physician) and diet.
4. The type of medication that I will be receiving, the frequency and range of dosages, the method by which I will take the medication, and duration of such treatment. The side effects of these drugs, known to commonly occur, and any side effects likely to occur in my case.
    - Nausea, vomiting, diarrhea –
        - Take with food. Consult with prescriber if it becomes bothersome
    - Dry mouth –
        - Suck on sugarless gum or candy. Call your prescriber if your mouth feels dry for more than 2 weeks.
    - Constipation –
        - Drink plenty of water and increase fiber in your diet.
    - Sleepiness –
        - May want to take medication at bedtime Decreased appetite Consult with your prescriber Fatigue - Try regular exercise
    - Sexual dysfunction –
        - Reversible, consult your prescriber.
    - Sweating –
        - Consult your prescriber
    - Dizziness –
        - Get up slowly. Do not drive or operate machinery until you know how this medication affects you.
    - Headache –
        - Talk to your prescriber.
    - Flu-like symptoms –
        - Report to prescriber if symptoms persist for longer than one week.
    - Weight gain –
        - Increase your physical activities. Avoid foods high in fat and sugar. Consult your prescriber if you have excessive weight gain.
    - Increased –
        - blood sugar or cholesterol Have your blood tested regularly (every 3-6 months) by your prescriber, especially if you have diabetes or heart problems

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MEDICATION CONSENT

Rare side effects may occur, in which situation you should call your prescriber immediately or go to the nearest emergency department - Extreme restlessness, suicidal thoughts, hallucinations, rash, muscle pain, fevers or chills, skin yellowing, increased breast size or milk production, edema, low blood pressure, bleeding, seizures, abnormal muscle or joint movements, difficulty speaking, swallowing or breathing, tremor or hair loss

I was given specific information about the recommended medication. I understand that this is only a partial listing of information, and I should discuss all my medical problems and any medication that I take with my physician(s) and my pharmacist(s). Prescribed agents may include the following: Antianxiety Agents (Xanax, Klonopin, Ativan…) Antidepressants (Zoloft, Paxil, Celexa, Lexapro, Wellbutrin, Cymbalta, Effexor…) Antipsychotics (Haldol, Zyprexa, Geodon, Risperdal, Seroquel…) Mood Stabilizer (Depakote, Lithium, Tegretol, Trileptal, Neurontin…) Psychostimulants (Adderall, Vyvanse, Concerta, Strattera, Ritalin…) Sedative/hypnotics (Vistaril, Trazodone, Remeron, Lunesta, Ambien…) And other psychoactive medications

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

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MEDICATION HISTORY FORM

SSRIs
- ☐ Sertraline (Zoloft)
- ☐ Fluoxetine (Prozac)
- ☐ Citalopram (Celexa)
- ☐ Escitalopram (Lexapro)
- ☐ Paroxetine (Paxil)
- ☐ Fluvoxamine (Luvox)

SNRI's
- ☐ Desvenlafaxine (Pristiq)
- ☐ Duloxetine (Cymbalta)
- ☐ Levomilnacipran (Fetzima)
- ☐ Venlafaxine (Effexor)

Dopamine Reuptake Inhibitor
- ☐ Bupropion (Wellbutrin)

S-HT1 Receptor Antagonist
- ☐ (Vistaril) Vilazodone (Viibyrd)

S-HT2 Receptor Antagonist
- ☐ Trazodone
- ☐ Nefazodone

S-HT3 Receptor Antagonist
- ☐ (Brintellix)

Noradrenergic antagonist
- ☐ Mirtazapine (Remeron)

Combo Meds
- ☐ Olanzapine/fluoxetine (Symbyax)

Herbs/Supplements
- ☐ St. John's Wort
- ☐ SAMe (S-Adenosylmethionine)

TCA's
- ☐ Amitriptyline
- ☐ Nortriptyline
- ☐ Doxepin

MAOI's
- ☐ Isocarboxazid (Marplan)
- ☐ Phenelzine (Nardil)
- ☐ Selegiline (Emsam) and Tranylcypromine (Parnate)

Bipolar Mood Stabilizers:
- ☐ Abilify - Aripiprazole (Mania/ Mixed/ Maintenance)
- ☐ Zyprexa - Olanzapine (Mania/ Mixed/ Maintenance)
- ☐ Seroquel - Quetiapine (Bipolar Depression/ Mania)
- ☐ Risperdal - Risperidone (Mania/ Mixed)
- ☐ Geodon - Ziprasidone (Mania/ Mixed)
- ☐ Saphris - Asenapine (Mania/ Mixed)
- ☐ Thorazine - Chlorpromazine·(Mania)
- ☐ Lithium (Mania/Maintenance/Anti-Suicidal)
- ☐ Carbamazepine (Rapid cycling/Manic/Mixed)
- ☐ Valproate (Mania/Rapid cycling/Aggression)
- ☐ Lamotrigine (Maintenance/Bipolar depression)

Off Label Mood Stabilizers:
- ☐ Oxcarbazepine
- ☐ Topiramate
- ☐ Gabapentin

Atypical Antipsychotics
- ☐ Aripiprazole (Abilify)
- ☐ Asenapine Maleate (Saphris)
- ☐ Clozapine (Clozaril)
- ☐ Iloperidone (Fanapt)
- ☐ (Lunesta) Lurasidone (Latuda)
- ☐ Olanzapine (Zyprexa) Vortioxetine
- ☐ Olanzapine/fluoxetine (Symbyax)
- ☐ Paliperidone (Invega)
- ☐ Quetiapine (Seroquel)
- ☐ Risperidone (Risperdal)
- ☐ Ziprasidone (Geodon)

Typical Antipsychotics
- ☐ Haloperidol (Haldol)
- ☐ Fluphenazine (Prolixin)
- ☐ Perphenazine (Trilafon)
- ☐ Thioridazine (Melleril or Mellaril)
- ☐ Thiothixene (Navane)

Anti-Anxiety Medications:
- ☐ Alprazolam (Xanax)
- ☐ Chlordiazepoxide (Librium)
- ☐ Clonazepam (Klonopin)
- ☐ Diazepam (Vallum)
- ☐ Lorazepam (Ativan)
- ☐ Buspirone (BuSpar}
- ☐ Hydroxyzine (Vistarill)
- ☐ Meprobamate (Equanil)
- ☐ Pregabalin (Lyrica)

Sleep Aids
- ☐ Trazodone (Oleptron)
- ☐ Mirtazapine (Remeron)
- ☐ Hydroxyzine
- ☐ Diphenhydramine (Benadryl)
- ☐ Amitriptyline (Elavil)
- ☐ Zolpidem (Ambien)
- ☐ Temazepam (Restoril)
- ☐ Eszopiclone (Lunesta)

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PRIVACY POLICY

This explains HIPAA laws and when and how our office can release information about you.

Protected health information includes descriptive information that can be used to identify a person and that relates to the treatment for a mental health condition. The protected health information includes information from the past, present, or future. The right to privacy continues after death.

Scottsdale Mental Health & Wellness Institute does not release health information about people who receive services from our office.

This means our office cannot release:

---Information that will tell people who you are or where you live

---Information about your mental health or condition

---Information about any of the services you are receiving

---Information about how your services are paid for

If you choose to sign a consent form for a person or facility; our office can release the requested information to only that person or facility. Our office is not required to release copies of records to individuals. The release of records to individuals is determined by the clinician.

There are some special circumstances when our office is required to release information about you, even if you have not given us permission to do so.

For example:

---If you are sick or hurt

---If you are not safe to take care of yourself

---if you try to hurt someone or someone is trying to hurt you

---If you tell us about child abuse

---Under a court order

By signing this form, you are stating that you have read and understand the terms stated within and have received a copy of the Notice of Privacy Practices.

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

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RELEASE OF INFORMATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization
   a. I authorize _____ to use and disclose the protected health information described below to SMHWI (individual seeking the information).
2. Effective Period
   a. This authorization for release of information covers the period of healthcare from:
   ☐ all past, present, and future periods **OR** ☐ _____ to _____
3. Extent of Authorization
   a. ☐ authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

Initial _____

****OR****

b. ☐ authorize the release of my complete health record with the exception of the following information:
☐ Mental health records ☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment (**Per CFR 42.2**) ☐ Other (please specify) _____

Initial _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

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CONSENT FOR TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

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PATIENT CONTRACT

Please read and sign below acknowledging that you have read, understand, and agree to the terms in this contract.

OFFICE HOURS: Our office hours are Monday to Friday 8:00 am– 5:00 p.m.

APPOINTMENTS: Co-payment, co-insurances, and/or deductibles are due at the time of service and any balances must be paid before future appointments can be scheduled.

FEES NOT COVERED BY INSURANCE: Fees for the items listed below are not covered by insurance companies and are the patient's responsibility. Fees for these items must be paid at the time the service is rendered and prior to the next scheduled appointment.

- Fees for no shows or cancellations less than 24 hours before the appointment
- $100 No show or late cancellation fee (99999)
- Fees for medical records sent to attorneys or other agencies (waived if sent directly to another provider, hospital, or insurance company)
- $50 Letter preparation fee (90889) • $1 per page fee for each page
- Fees for returned checks
- Fees for disability forms, FMLA forms, or letter preparation
- $25 per five minutes phone consultation fee, billed in 5-minute for patients who choose to contact a provider after hours for a non-emergency, will be billed for a phone consultation.

FEES FOR CASH PAY PATIENTS: This is not a comprehensive list of all fees in this office; please inquire about current fees prior to authorizing any service that is not covered by your insurance company.

- $400 for initial psychiatric evaluation (99205)
- $200 Moderate Complexity Medication Management (99214)
- $50 Urine Drug Screen (80305)
- $100 Psychotherapy add-on (90833)
- $200 for Initial New Therapy (90791)
- $120 for Established Therapy (90837)
- $100 Group therapy (90853)
- $100 Disability and/or FMLA Form preparation (up to 5 pages) (90889)
- $25 per five minutes phone consultation fee, billed in 5-minute increments (99441-3)

INSURANCE & PATIENT RESPONSIBILITY: It is the patient's responsibility to notify us with any insurance changes and to obtain any required authorizations. Our office will submit claims to the insurance company we have on file. Per our contractual obligation with insurance companies, we must collect all co- payments and/or deductibles due from the patient at the time of service unless other arrangements have been made in advance. Should the insurance company not cover the service, the balance may become payable by you. Any balance due from the client that is not paid within 90 days will be referred to a collection agency.

- You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection effort.

PRESCRIPTION REFILLS: All prescription refills are handled during appointments exclusively, if you need a refill and do not have an appointment, please contact your pharmacy and they will contact us. WE DO NOT FILL EMAIL OR TELEPHONE REQUESTS MADE BY THE PATIENT NOT FROM THE PHARMACY.

RELEASE OF RECORDS: All patients or their parent/legal guardian must sign a release authorizing the release of any information. No information will be released without a properly executed consent. Record requests may take up to 30 days to process and payment is required.

REASONS FOR TERMINATION: The reasons listed below are common reasons for termination from our office. This list is not comprehensive, and the treating provider has final authority on terminating treatment.

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PATIENT CONTRACT

- Continuously canceling or not showing for scheduled appointments
- Not following the recommended treatment plan
- If the patient is not seen within 6 months, unless otherwise instructed by your provider, your file will be closed (voluntarily terminated) and no prescriptions will be authorized for refills until you are seen.

EMERGENCY CONTACT NUMBERS: We are an out-patient practice. The emergency phone numbers provided on the office voicemail are for after-hour urgent issues that are not life threatening. If you are experiencing a life-threatening emergency such as violent or suicidal thoughts, you must call 911 immediately. CONFIDENTIALITY: In accordance with moral, ethical, and legal guidelines regarding your right to confidentiality, a patient's personal information is carefully guarded. However, there are some exceptions which must be noted:

- If a patient poses a threat to his or her own safety or the safety of others, we are required to notify concerned parties and the authorities.
- If a patient reports actual or suspected abuse of any individual, our office must notify the proper authorities.
- In patient groups of two or more, including the lobby and check-out, confidentiality is urged but not guaranteed.

CREDIT CARD AUTHORIZATION: I allow SMHWI to automatically charge my credit card for any outstanding balances. These may include; insurance denials for ANY reason, missed or canceled appointments, deductibles, coinsurances, partially paid claims.

- Missed or canceled appointments without 24-hour notice will be charged $100.00.

AUTHORIZATION & SIGNATURE ON FILE: By signing this form, I authorize Scottsdale Mental Health & Wellness Institute to release all necessary information to insurance companies to process claims or obtain authorization for treatment. I authorize payments to be made to {Enter Provider Name} from insurance companies, government agencies, or any other agency providing benefits for services rendered. I authorize that a copy of the signature below may substitute as the original.

I have read, understood, and agree to follow all terms and conditions of this contract.

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Scottsdale
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CREDIT CARD AUTHORIZATION FORM

Thank you for choosing Scottsdale Mental Health and Wellness Institute (SMHWI) for your mental health needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to our patients, you, the insured. This is driving many practices to adopt new financial policies to enable more efficient operational processes. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit.

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, SMHWI will require all patients keep an active credit card on file with us. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of patient responsibility. Circumstances when your card would be charged include but are not limited to: missed or canceled sessions without 24-hour notice ($100), missed co- payments, deductible and coinsurance, any non-covered services and/or denial of services, including the first/psychiatric assessment appointment.

- Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility balance owed, it is your responsibility to contact your insurance carrier immediately.
- When we receive the EOB, we will enter all pertinent payment information into our system. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be sent to you.

If the credit card we have on file for you changes, please notify your clinicians IMMEDIATELY by phone or email. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days.

We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office.

If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the same card in a timely manner. We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account) or Flex Plan Card on File. You may also pay for the visit with cash or a personal check.

By signing below, I agree to the SMHWI Credit Card on File Policy and I authorize SMHWI to keep my signature and a valid credit/debit card number securely on-file in my account. I allow SMHWI to automatically charge my credit card for any outstanding balances. These may include; insurance denials for ANY reason (including no referral on file), deductibles, coinsurances, partially paid claims, and missed or canceled appointments without 24-hour notice will be charged the full $100.00 fee.

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CREDIT CARD AUTHORIZATION FORM

If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give SMHWI a new, valid credit card which I will allow them to key-in over the phone. Even though SMHWI is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed here and may be used with the same authorization as the original card which I presented in person.

I understand that I am responsible for payment for all medical services provided to me by SMHWI. I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to allow SMHWI to immediately charge my credit card on file for the balance if that happens. I understand that this form is valid until I cancel this authorization through written notice to SMHWI.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us this authorization will remain in effect until canceled.

Credit Card Information

Card Type: ☐ Mastercard ☐ VISA ☐ Discover ☐ American Express

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____/_____ CVV2: _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____ , authorize SMHWI to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

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NO SHOW/ LATE FEE CONTRACT

Thank you for trusting your medical care to Scottsdale Mental Health and Wellness Institute. When you schedule an appointment with SMHWI we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 48 hours prior to your scheduled appointment.

This gives us time to schedule other patients who may be waiting for an appointment. This policy will be strictly enforced. This policy is non-negotiable. Please see our Appointment Cancellation/No Show Policy below:

Please initial by each statement

_____Phone reminders are a courtesy only. It is a patient responsibility to remember the date and appointment time.

_____Any cancellation with less than 48 hours' notice will be considered a late cancellation. There will be no disputes about what constitutes a "valid" reason for canceling. The time will be measured to the minute (i.e. 47 hours, 59 minutes is less than 48 hours).

_____There will be a $100.00 charge for all no shows and late cancellations.

_____The second no show or late cancellation will be charged the full fee.

_____The third no show or late cancellation will be charged the full fee and will result in discharge from the practice

_____Fees will be automatically charged to credit/debit cards if this has been your form of payment in the past. Patients that pay cash or by check must arrange for payments to be made before an appointment will be rescheduled.

_____No-show/late cancel fees cannot be billed to the patient's insurance company and will be charged to the credit/debit card on file.

_____Any new patient who fails to show for their initial visit will not be rescheduled.

Patients who are transferred out of the practice (or who do not agree with this policy) will receive an official letter documenting termination of the physician/patient relationship, a list of other area psychiatrists, and possibly prescriptions for up to 3 months of the last medication regimen prescribed depending on the circumstances of the situation. This will be mailed via certified mail with a return receipt (i.e. must be signed for) to the address on file (so please inform me of any changes in address).

My signature below affirms that I agree to all terms of this policy.

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

Scottsdale
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NON-INSURANCE FEE SCHEDULE

The fees outlined below are effective 01/01/2020 and may be changed at any time.

This is not a comprehensive list of all fees in this office; please inquire about current fees prior to authorizing any service that is not covered by your insurance company.

- $400 for initial psychiatric evaluation (99205)
- $200 Moderate Complexity Medication Management (99214)
- $30 Urine Drug Screen (80305)
- $100 Psychotherapy add-on (90833)
- $100 Group therapy (90853)
- $100 No show or late cancellation fee (99999)
- $50 Letter preparation fee (90889) with $1 fee for each page for records (waived if sent directly to another provider, hospital, or insurance company)
- $100 Disability and/or FMLA Form preparation (up to 5 pages) (90889)
- $25 per five minutes phone consultation fee, billed in 5-minute increments (99441-3)
- $150 for Emotional Support Animal documentation (C9995)

Requires two attended sessions before the letter is written and two additional sessions within the year to renew the letter.

I have read, understood, and agree to the above fees.

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Date: _____

Scottsdale
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A. Notifier: Scottsdale Mental Health and Wellness. 8350 E. Raintree Dr. Suite 130 Scottsdale, AZ 85260

B. Patient Name: _____ C. Insurance:

_____

Advance Beneficiary Notice of Non- Coverage (ABN)

Note: If insurance doesn't pay for **D. _ Service_** below, you may have patient responsibility. Insurance does not pay for everything. Even some care that you or your healthcare provider have good reason to think you need. We expect insurance may not pay for the **D._Service_** Below

D.	E. Reason insurance may not pay	F . Estimated Cost
Service		Psychiatry- $400/$200 Therapy- $200/$120

What you need to know:
Read this notice, so you can make an informed decision about your care. Ask us any question you may have after you finish reading or reach out to your insurance company.

Choose an option below about whether to receive a Service

G. Options: Check only one box. We cannot choose a box for you.
☐ *Option 1*. I want the **Services** above. I understand that if my insurance doesn't pay, I am responsible for payment to SMHWI. ☐ *Option 2*. I want the **service** listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment at time of service. ☐ *Option 3*. I don't want the **Service** listed above

H. Additional information:

I. **Signature:**	J. **Date:**

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R9-10-1008. Patient Rights

A. An administrator shall ensure that:

1) The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises.
2) At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C)
3) Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include: How and when a patient or the patient's representative is informed of the patient rights in subsection (C), and where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:

1) A patient is treated with dignity, respect, and consideration
2) A patient is not subjected to:
    a) Abuse;
    b) Neglect;
    c) Exploitation;
    d) Coercion;
    e) Manipulation
    f) Sexual abuse;
    g) Sexual assault;
    h) Except as allowed in R9-10-1012(B), restraint or seclusion;
    i) Retaliation for submitting a complaint to the Department or another entity;
    j) Misappropriation of personal and private property by an outpatient treatment center's personnel members, employee, volunteer, or student

3. A patient or the patient's representative:

    a) Except in an emergency, either consents to or refuses treatment;
    b) May refuse or withdraw consent for treatment before treatment is initiated,
    c) Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure.
    d) Is informed of the following:
        i. The outpatient treatment center's policy on health care directives, and
        ii. The patient complaint process;
    e) and Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
    f) Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
        i. Medical record, or
        ii. Financial records.

C. A patient has the following rights:

1) Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
2) To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
3) To receive privacy in treatment and care for personal needs;
4) To review, upon written request, the patient's own medical record according to AR.S. 12-2293, 12-2294, and 12-2294.01;
5) To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient.
6) To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7) To participate or refuse to participate in research or experimental treatment, and
8) To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

Name _____

Signature _____ Date _____

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INSTITUTE

Your Rights Pursuant to Arizona Administrative Code, Title 9, Chapter 10, Article 9 (Outpatient Surgical Center R9-10- 909) and Article 10 (Outpatient Treatment Centers R9-10-1008)

A patient is treated with dignity, respect and consideration;
A patient is not subjected to:

- Abuse; neglect; exploitation; coercion; manipulation; sexual abuse or assault;
- Restraint or seclusion, except as allowed in R9-10-1012(B) if the center is authorized to provide behavioral health observation/stabilization services;
- Retaliation for submitting a complaint to the Arizona Department of Health Services or another entity; or
- Misappropriation of personal and private property by the center's personnel members, employees, volunteers or students; and

A patient or the patient's representative has the right to:
Consent to or refuse treatment, except in an emergency;
Refuse or withdraw consent for treatment before treatment is initiated;
Be informed of:

- Except in an emergency, alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
- Policies and procedures on health care directives; and
- The patient complaint process

Consent to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to the center for identification and administrative purposes; and
Except as otherwise permitted by law, provide written consent to the release of information in the patient's medical record or financial records.

A patient has the following rights:

- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status or diagnosis;
- To receive treatment that supports and respects the patient's individuality, choices, strengths and abilities;
- To receive privacy in treatment and care for personal needs;
- To review, upon written request, the patient's own medical record according to ARS 12-2293, 12-2294 and 12- 2994.01;
- To receive a referral to another health care institution if the center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
- To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
- To participate or refuse to participate in research or experimental treatment; and
- To receive assistance from a family member, representative or other individual in understanding, protecting or exercising the patient's rights.

Name _____

Signature _____ Date _____

Scottsdale
Mental Health & Wellness
INSTITUTE

ADVANCE DIRECTIVES ACKNOWLEDGMENT

Medical/Healthcare Advance Directives

- ☐ I HAVE NOT executed an Advance Directive
- ☐ I HAVE executed an Advance Directive
  - ☐ I HAVE NOT provided the facility with a copy of the Advance Directive
  - ☐ I HAVE provided the facility with a copy of the Advance Directive

Mental Health Advance Directives

- ☐ I HAVE NOT executed an Advance Directive
- ☐ I HAVE executed an Advance Directive
  - ☐ I HAVE NOT provided the facility with a copy of the Advance Directive
  - ☐ I HAVE provided the facility with a copy of the Advance Directive

I acknowledge the following:

- I have been informed of my rights to formulate Advance Directives.
- I understand that I am not required to have Advance Directives in order to receive treatment at this facility.
- I understand the terms of any Advance Directive I have executed will be followed by the facility and my caregivers to the extent permitted by law.
- Under NO circumstances will a DO NOT RESUSCITATE order be honored at Scottsdale Mental Health & Wellness Institute. All patients who are or become non-responsive will be resuscitated within the facilities capabilities and transferred to the closest medical facility.

For more information and forms on Advance Directives you can contact the Office of the Arizona Attorney General.

Office of Arizona Attorney General
Life Care Planning Information and Documents Direct Line: 602-542-2123
Toll Free: 800-352-8431
Fax: 602-364-1970

_____
Print Name

_____
Patient Signature

_____
Legal Guardian

_____
Legal Guardian Name/POA