Scottsdale
Mental Health & Wellness
INSTITUTE

Patient Information

Patient Name: First MI Last Nickname/Preferred Name:

_____ _____

Birthdate:____/____/____SS#:____-____-____Sex: ☐ M or ☐ F

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): First MI Last

_____ Relationship: _____

Primary Phone #: _____ Secondary Phone#: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Emergency Contact (If different than above)

Name (First Last): _____ Relationship: _____

Primary Phone #: _____ City/State: _____

Insurance Info

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

Company:_____ Birthdate:____/____/____ SS#:____-____-____

Group #:_____ Policy #:_____

Street Address(if different than above) City State Zip Code P.O. Box

_____

Primary Phone #: _____ Secondary Phone #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits 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:_____

Why I want to be seen/Mental health history: please give a brief description of concerns/previous diagnosis

_____

_____

_____

_____

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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 recommend by your health care 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: _____

SMHWI
Phone: 480-508-0882
Fax: 480-508-0891
8350 E Raintree Dr Suite 130 and 125
Scottsdale Az, 85260

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Medication Consent

My physician and I _____,_____ (name and date of birth) discussed:

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/ ☐ Delusional 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.
   - Agitation, anxiety, nervousness –
     - Typically, short-term as you adjust to the medicine. Contact provider if becomes persistent.
   - 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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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). Prescribe agents my 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

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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.

- $350 for initial psychiatric evaluation (99205)
- $125 Moderate Complexity Medication Management (99214)
- $30 Urine Drug Screen (80305)
- $100 Psychotherapy add-on (90833)
- $100 Group therapy (90853)
- $50 No show or late cancellation fee (99999)
- $25 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)

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

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 rescheduled 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 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 cancelling. The time will be measured to the minute (i.e. 47 hours, 59 minutes is less than 48 hours).

_____ There will be a $50.00 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 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 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 the all terms of this policy.

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Signature of Patient or Guardian: _____

Date: _____

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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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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
- • $50 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)
  - • $25 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.

• $350 for initial psychiatric evaluation (99205)
• $125 Moderate Complexity Medication Management (99214)
• $30 Urine Drug Screen (80305)
• $100 Psychotherapy add-on (90833)
• $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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- 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, 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 cancelled appointments, deductibles, coinsurances, partially paid claims.

- Missed or cancelled appointments without 24-hour notice will be charged $50.00.

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 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: _____

Date: _____

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Release of Information to Others From SMHWI

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

I authorize SMHWI (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

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 ☐ I 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).

OR

b ☐ I 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 □ Other (please specify): _____

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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Release of Information to SMHWI

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

I authorize _____ to use and disclose the protected health information described below to SMWHI (individual seeking the information).

2. Effective Period
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 ☐ I 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).
OR

b ☐ I 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 ☐ Other (please specify): _____

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.

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