Arizona Psychiatry and Neuroscience Institute

2152 S. Vineyard Ave, Bldg. 12, Suite 138, Mesa, Arizona 85210
PHONE: (480) 967-6888; FAX (480) 967-6887

NEW PATIENT PACKET

DEMOGRAPHIC DATA

Patient Name: _____

Date of birth: ____/____/_____ Age: ____ Gender: ☐ Male ☐ Female

Responsible Party Name: _____

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other _____

Race: ☐ Caucasian ☐ Asian ☐ African/American ☐ Hispanic ☐ Native American ☐ Other

Marital Status: ☐ Married ☐ Never married ☐ Divorced ☐ Widowed ☐ Cohabitation

Reason for today's visit: _____

How long has the problem been going on?

_____

Rate the problem(s) during the past month (1 least severe - 10 most severe): 1 2 3 4 5 6 7 8 9 10

Patient Social Security # _____

Mailing Address: _____City, State, Zip: _____

Permanent Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Employer Name: _____ Employer Phone #:_____

Email Address: _____

Emergency Contact Name and #: _____

Pharmacy Name: _____ City: _____ Major cross streets _____

Primary Care Doctor's Name and Number: _____

Referring Doctor's Name and Number: _____

Billing Information: I prefer you bill my claim to:

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Do you have Medicare? Yes ☐ No ☐ If yes, what is your Medicare #: _____

PSYCHIATRIC HISTORY

PAST PSYCHIATRIC HISTORY

Outpatient Treatment: ☐ None ☐ Therapy only ☐ Meds only ☐ Therapy/Meds ☐ Other
Previous psychiatrists, most recent first:

_____

What were you treated for?

_____

Do you currently have a therapist? ☐ No ☐ Yes Length of time with current therapist:_____
Therapist's name: _____
Phone #: _____
Therapist's address:

_____

Reason for seeking therapy:

_____

Has therapy been helpful? ☐ Not much ☐ A little ☐ Somewhat ☐ Very

Day program or partial hospitalization? ☐ No ☐ Yes

Name of Facility	Dates/Length of Stay	Reason	Outcome

Inpatient Treatment (hospitalizations, residential treatment centers, etc.)

Name of Facility	Dates/Length of Stay	Reason	Outcome

Have you ever made a suicide attempt? ☐ Yes ☐ No
Please explain: _____

MEDICAL HISTORY

Primary care physician (PCP):

_____

PCP phone #: _____ Fax #: _____
PCP address: _____
Physical exam in the past year? ☐ No ☐ Yes
Findings: _____

Current Medications - include medical, psychiatric, over-the-counter, herbal treatments and supplements.

Medication	Dose (mg)	Instructions	Effectiveness	Side Effects

Has there been any recent changes in your medication? ☐ No ☐ Yes

Explain: _____

Previous Psychiatric Medications

Medication	Duration of Trial	Effectiveness	Side Effects

Medication allergies? ☐ No ☐ Yes

Name of Drug and reaction:

_____

Current Medical Problems:

_____

Past Medical Problems:

_____

Surgeries: _____

Ever had a seizure? ☐ No ☐ Yes

Ever suffered a head injury? ☐ No ☐ Yes

Did head injury result in loss of consciousness? ☐ No ☐ Yes

How long were you unconscious?

_____

Ever had an MRI or CAT scan of the head? ☐ No ☐ Yes

Date/Results: _____

Ever had an EEG (test for seizures)? ☐ No ☐ Yes

Date/Results: _____

Ever had an EKG (heart test)? ☐ No ☐ Yes

Date/Results: _____

FAMILY MEDICAL HISTORY

The following questions refer to persons related by blood only, including extended family. List history of thyroid disease, heart disease, epilepsy, migraines, diabetes mellitus, autoimmune disease (i.e. lupus), or other.

Family member and diagnosis details:

_____

SOCIAL AND DEVELOPMENTAL HISTORY

Childhood History

Did you experience any serious/chronic medical illnesses as a child? ☐ No ☐ Yes
Explain: _____

Did you experience any problems in school, with learning, or in development? ☐ No ☐ Yes
Explain: _____

Were you adopted? ☐ No ☐ Yes

Time in foster care/group homes? ☐ No ☐ Yes How Many? _____
Who raised you? _____

Did either parent die in childhood? ☐ No ☐ Yes
If yes, how old were you? _____

What was your parents cause of death:

_____

Were there problems in your family such as domestic violence, alcohol/drug abuse, conflict, physical/emotional neglect that may have affected you? ☐ No ☐ Yes
Explain: _____

Growing up, problems getting along with others or making friends? ☐ No ☐ Yes
Explain: _____

How would you describe your childhood in general:

_____

How would you describe your parent(s)/caretaker(s):

_____

What was your Parent(s)/caretaker(s) occupation:

_____

As a child, did you experience:

☐ neglect ☐ physical abuse ☐ sexual abuse ☐ verbal abuse
If so who was the Perpetrator:

_____

How often did abuse occur?

_____

Any other information regarding abuse you wish to share:

_____

As an adult, have you experienced any of the following:

☐ Rape ☐ Spousal abuse ☐ Combat/war trauma ☐ Natural disaster ☐ Assault

☐ Witnessed violent/traumatic event ☐ Someone close committed suicide ☐ Other

Please explain: _____

Adult History

How many times married? _____

Are you currently employed? ☐ No ☐ Yes

If so, occupation: _____

Have you had difficulty holding a job? ☐ No ☐ Yes

Explain: _____

What other type of work have you done:

_____

Please list all persons living in your household:

Name	Age	Relationship

Educational History

What was the highest grade in school you completed:

_____

Were you ever diagnosed with a learning disability? ☐ No ☐ Yes _____

Have you ever received special education services? ☐ No ☐ Yes _____

Did you have problems with hyperactivity or concentration problems in school?

☐ No ☐ Yes

On average, what kind of grades did you get:

_____

Legal History

Do you have any legal issues pending such as lawsuit, bankruptcy, custody case, misdemeanor/felony charges, or workman's comp issue? ☐ No ☐ Yes

Please describe charges/court dates/relevant data:

_____

Have you ever been arrested? ☐ No ☐ Yes

If so, what were the charges:

_____

Have you ever been incarcerated? ☐ No ☐ Yes

What for? _____

How long were you incarcerated for?

_____

SUBSTANCE ABUSE HISTORY

Do you have a history of substance abuse? ☐ No ☐ Yes
If yes, what substances have you used:

_____

Do you currently use drugs, alcohol, or tobacco? ☐ No ☐ Yes
If yes, what do you use? _____
How Frequently do you use drugs, alcohol, or Tobacco? _____
Have drugs or alcohol ever affected your ability to perform your job or home duties, impaired relationships, or caused medical or legal problems? ☐ No ☐ Yes
Explain:

_____
_____
_____
_____

Have you ever had outpatient substance abuse treatment? ☐ No ☐ Yes

Therapist/Program/Facility	Dates of Treatment	Outcome

Have you ever had Inpatient substance abuse treatment? ☐ No ☐ Yes

Hospital	Dates of Treatment	Outcome

FAMILY PSYCHIATRIC HISTORY

The following questions refer to blood relatives only. List relatives with depression, severe mood swings, postpartum depression, anger-control problems, anxiety, alcohol/drug abuse, learning problems, substance abuse, bipolar disorder, or schizophrenia.

Family member and diagnosis:

_____
_____
_____

Has any family member been hospitalized in psychiatric facility? ☐ No ☐ Yes
If yes, who was it and why were they hospitalized? _____
Has any family member attempted or completed suicide? ☐ No ☐ Yes
If yes, who was it and by what method did they do?_____

REVIEW OF PSYCHIATRIC SYMPTOMS

Please check any symptoms experienced in the past year.

Physical Symptoms

☐ problems falling asleep/staying asleep
☐ sleeping a lot
☐ increased/decreased appetite
☐ weight gain/loss
☐ tiredness
☐ frequent headaches/aches and pains
☐ bowel/bladder incontinence
☐ agitation/restlessness

Cognitive Symptoms

☐ confusion/disorientation
☐ decreased concentration
☐ memory problems
☐ difficulty thinking

Psychological Symptoms

☐ sad/depressed mood
☐ loss of interest in activities
☐ decreased motivation
☐ wishing you were dead
☐ thoughts of committing suicide
☐ thoughts of hurting others
☐ irritable mood
☐ mood swings
☐ phobias
☐ repetitive distressing thoughts
☐ periods of elevated mood/excessive talking/giddy behavior/uncontrollable laughing
☐ hearing voices
☐ seeing things
☐ fear someone is trying to hurt you
☐ feeling watched
☐ fear of being alone
☐ excessive worrying
☐ afraid to go out
☐ wanting to be alone
☐ nightmares
☐ feeling out-of-control

Behavioral Symptoms

☐ compulsive behavior/rituals
☐ assaulting others
☐ arguing a lot
☐ anger outbursts/rages
☐ excessive spanking of children
☐ excessive yelling at children/spouse
☐ breaking things
☐ frequent absences from work
☐ often late for work
☐ compulsive need to lie
☐ shoplifting/stealing
☐ gambling
☐ excessive spending/shopping
☐ increased desire for sex
☐ withdrawal from family/friends
☐ decreased social activity

BEHAVIORAL HEALTH SCREEN

Name: _____

DOB: _____

Gender: ☐ Female ☐ Male

Today's Date: _____

Please complete the following based on how you feel **RIGHT NOW**.

A. Please put a check on the box below that best describes your outlook on the future

☐ 0 Positive view of my future

☐ 1 Uncertain about the future

☐ 2 Nothing to look forward to

☐ 3 Future feels hopeless / cannot improve

B. Please check the box below that describes your thoughts of ending your life

☐ 0 No thoughts of killing myself

☐ 1 Thoughts, but would not carry them out

☐ 2 Would like to kill myself

☐ 3 Would kill myself if I had the chance

C. Please put a check on the box below that describes your Drug or alcohol use during the last two weeks

☐ 0 Have not used

☐ 1 Have not increased use

☐ 2 Increased use more days than not

☐ 3 Increased use every day

QUESTIONNAIRE

PATIENT NAME: _____

DATE: _____

Check the box that BEST describes how you have felt over the past 6 months.

1. How often do you have trouble wrapping up the final details of a project, one the challenging parts have been done?

☐ NEVER ☐ RARELY ☐ SOMETIMES ☐ OFTEN ☐ VERY OFTEN

2. How often do you have difficulty getting things in order when you have a task to do that requires organization?

☐ NEVER ☐ RARELY ☐ SOMETIMES ☐ OFTEN ☐ VERY OFTEN

3. How often do you have problems remembering appointments or obligations?

☐ NEVER ☐ RARELY ☐ SOMETIMES ☐ OFTEN ☐ VERY OFTEN

4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?

☐ NEVER ☐ RARELY ☐ SOMETIMES ☐ OFTEN ☐ VERY OFTEN

5. How often do you fidget or squirm with your hands or feet when you have to sit for a long periods of time?

☐ NEVER ☐ RARELY ☐ SOMETIMES ☐ OFTEN ☐ VERY OFTEN

6. How often do you feel overly active and compelled to do things, as if driven by a motor?

☐ NEVER ☐ RARELY ☐ SOMETIMES ☐ OFTEN ☐ VERY OFTEN

SCREENING FOR MOOD DISORDER

Instructions: Please check ONE box only for each question.

Part One

1. Has there ever been a period of time when you were not your usual self and…

… you felt so good or hyper that other people thought you were not your normal self, or you got into trouble? ☐ YES ☐ NO

…. you were so irritable that you shouted at people or started fights or arguments? ☐ YES ☐ NO

… you felt much more self-confident than usual? ☐ YES ☐ NO

… you got much less sleep than usual and didn't really miss it? ☐ YES ☐ NO

… you were much more talkative or spoke much faster than usual? ☐ YES ☐ NO

… your thoughts raced through your head or you couldn't slow your mind down? ☐ YES ☐ NO

… you were so easily distracted that you had trouble concentrating or staying on track? ☐ YES ☐ NO

… you had much more energy than usual? ☐ YES ☐ NO

… you were much more active or did many more things than usual? ☐ YES ☐ NO

… you were much more social or outgoing than usual? ☐ YES ☐ NO

… you were much more interested in sex than usual? ☐ YES ☐ NO

… you did things unusual for you that other people might have thought excessive, foolish, or risky? ☐ YES ☐ NO

… you spent money that got you or your family into trouble? ☐ YES ☐ NO

Part Two

Did several of the situations you said YES to ever happen during the same period of time? ☐ YES ☐ NO

Part Three

How much of a problem did any of these cause you?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

Please discuss the results of this questionnaire with your physician.

YES / NO QUESTIONNAIRE

Circle or check one answer for each sentence.

1. ☐ Yes ☐ No I have trouble making up my mind.
2. ☐ Yes ☐ No I get nervous when things do not go the right way for me.
3. ☐ Yes ☐ No Others seem to do things easier than I can.
4. ☐ Yes ☐ No I like everyone I know.
5. ☐ Yes ☐ No Often I have trouble getting my breath.
6. ☐ Yes ☐ No I worry a lot of the time.
7. ☐ Yes ☐ No I am afraid of a lot of things.
8. ☐ Yes ☐ No I am always kind.
9. ☐ Yes ☐ No I get mad easily.
10. ☐ Yes ☐ No I worry about what my parents will say to me.
11. ☐ Yes ☐ No I feel that others do not like the way I do things.
12. ☐ Yes ☐ No I always have good manners.
13. ☐ Yes ☐ No It is hard for me to get to sleep at night.
14. ☐ Yes ☐ No I worry about what other people think about me.
15. ☐ Yes ☐ No I feel alone even when there are people with me.
16. ☐ Yes ☐ No I am always good.
17. ☐ Yes ☐ No Often I feel sick in my stomach.
18. ☐ Yes ☐ No My feelings get hurt easily.
19. ☐ Yes ☐ No My hands feel sweaty.
20. ☐ Yes ☐ No I am always nice to everyone.
21. ☐ Yes ☐ No I am tired a lot.
22. ☐ Yes ☐ No I worry about what is going to happen.
23. ☐ Yes ☐ No Other people are happier than I am.
24. ☐ Yes ☐ No I tell the truth every single time.
25. ☐ Yes ☐ No I have bad dreams.
26. ☐ Yes ☐ No My feelings get hurt easily when I am fussed at.
27. ☐ Yes ☐ No I feel someone will tell me I do things the wrong way.
28. ☐ Yes ☐ No I never get angry.
29. ☐ Yes ☐ No I wake up scared some of the time.
30. ☐ Yes ☐ No I worry when I go to bed at night.
31. ☐ Yes ☐ No It is hard for me to keep my mind on my schoolwork.
32. ☐ Yes ☐ No I never say things I shouldn't.
33. ☐ Yes ☐ No I wiggle in my seat a lot.
34. ☐ Yes ☐ No I am nervous.
35. ☐ Yes ☐ No A lot of people are against me.
36. ☐ Yes ☐ No I never lie.
37. ☐ Yes ☐ No I often worry about something bad happening to me.

BECK'S DEPRESSION INVENTORY ASSESSMENT

INSTRUCTIONS:

For each question, circle the number by the response that best describes how you have felt during the past seven days.

Make sure you circle one answer for each question (1-21). If more than one response applies to how you have been feeling during the past seven days, select the higher-numbered response.

PATIENT NAME:

_____

DATE:

_____

BECK'S DEPRESSION INVENTORY

1.

☐ 0 I do not feel sad.

☐ 1 I feel sad.

☐ 2 I am sad all the time and I can't snap out of it.

☐ 3 I am so sad and unhappy that I can't stand it.

2.

☐ 0 I am not particularly discouraged about the future.

☐ 1 I feel discouraged about the future.

☐ 2 I feel I have nothing to look forward to.

☐ 3 I feel that the future is hopeless and that things cannot improve.

3.

☐ 0 I do not feel like a failure.

☐ 1 I feel I have failed more than the average person.

☐ 2 As I look back on my life, all I can see is a lot of failures.

☐ 3 I feel I am a complete failure as a person.

4.

☐ 0 I get as much satisfaction out of things as I used to.

☐ 1 I don't enjoy things the way I used to.

☐ 2 I don't get real satisfaction out of anything anymore.

☐ 3 I am dissatisfied or bored with everything.

5.

☐ 0 I don't feel particularly guilty.

☐ 1 I feel guilty a good part of the time.

☐ 2 I feel quite guilty most of the time.

☐ 3 I feel guilty all of the time.

6.

☐ 0 I don't feel I am being punished.

☐ 1 I feel I may be punished.

☐ 2 I expect to be punished.

☐ 3 I feel I am being punished.

7.

☐ 0 I don't feel disappointed in myself.

☐ 1 I am disappointed in myself.

☐ 2 I am disgusted with myself.

☐ 3 I hate myself.

8.

☐ 0 I don't feel I am any worse than anybody else.

☐ 1 I am critical of myself for my weaknesses or mistakes.

☐ 2 I blame myself all the time for my faults.

☐ 3 I blame myself for everything bad that happens.

9.

☐ 0 I don't have any thoughts of killing myself.

☐ 1 I have thoughts of killing myself, but I would not carry them out.

☐ 2 I would like to kill myself.

☐ 3 I would kill myself if I had the chance.

10.

☐ 0 I don't cry any more than usual.

☐ 1 I cry more now than I used to.

☐ 2 I cry all the time now.

☐ 3 I used to be able to cry, but now I can't cry even though I want to.

11.

☐ 0 I am no more irritated by things than I ever was.

☐ 1 I am slightly more irritated now than usual.

☐ 2 I am quite annoyed or irritated a good deal of the time.

☐ 3 I feel irritated all the time.

12.

☐ 0 I have not lost interest in other people.

☐ 1 I am less interested in other people than I used to be.

☐ 2 I have lost most of my interest in other people.

☐ 3 I have lost all of my interest in other people.

13.

☐ 0 I make decisions about as well as I ever could.

☐ 1 I put off making decisions more than I used to.

☐ 2 I have greater difficulty in making decisions more than I used to.

☐ 3 I can't make decisions at all anymore.

14.

☐ 0 I don't feel that I look any worse than I used to.

☐ 1 I am worried that I am looking old or unattractive.

☐ 2 I feel there are permanent changes in my appearance that make me look unattractive.

☐ 3 I believe that I look ugly.

15.

☐ 0 I can work about as well as before.

☐ 1 It takes an extra effort to get started at doing something.

☐ 2 I have to push myself very hard to do anything.

☐ 3 I can't do any work at all.

16.

☐ 0 I can sleep as well as usual.

☐ 1 I don't sleep as well as I used to.

☐ 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

☐ 3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

☐ 0 I don't get more tired than usual.

☐ 1 I get tired more easily than I used to.

☐ 2 I get tired from doing almost anything.

☐ 3 I am too tired to do anything.

18.

☐ 0 My appetite is no worse than usual.

☐ 1 My appetite is not as good as it used to be.

☐ 2 My appetite is much worse now.

☐ 3 I have no appetite at all anymore.

19.

☐ 0 I haven't lost much weight, if any, lately.

☐ 1 I have lost more than five pounds.

☐ 2 I have lost more than ten pounds.

☐ 3 I have lost more than fifteen pounds.

20.

☐ 0 I am no more worried about my health than usual.

☐ 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.

☐ 2 I am very worried about physical problems and it's hard to think of much else.

☐ 3 I am so worried about my physical problems that I cannot think of anything else.

21.

☐ 0 I have not noticed any recent change in my interest in sex.

☐ 1 I am less interested in sex than I used to be.

☐ 2 I have almost no interest in sex.

☐ 3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Total Score: _____ Levels of Depression: _____

1-10: These ups and downs are considered normal

11-16: Mild mood disturbance

17-20: Borderline clinical depression

21-30: Moderate depression

31-40: Severe depression

Over 40: Extreme depression

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CONSENT TO PSYCHIATRIC TREATMENT

Patient Name: _____ Date of Birth: _____/_____/_____

You understand that psychiatric treatment may include psychiatric evaluation, diagnosis, medication management, psychotherapy, and other mental health services as clinically appropriate.

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 medication or test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

By signing below, you confirm that you have had the opportunity to ask questions and voluntarily consent to psychiatric treatment.

Patient Signature: _____ Date: _____/_____/_____

NOTICE OF PRIVACY PRACTICE FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclose and how you can get access to this information. Please review it carefully.

In compliance of the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Arizona Psychiatry and Neuroscience Institute, has established privacy policies and procedures relating to the protected health information of our patients. Protected health information is information related to your past, present, or future physical or mental health or condition, or payment for such, in which you personally could be identified. HIPAA requires that providers must maintain the privacy of protected health information, provide a notice of their legal duties and privacy practices, and abide by the terms of the privacy notice currently in effect.

If you have any questions about our privacy practices or any of the information contained in this Notice of Privacy Practices for Protected Health Information ("Notice"), or wish to register any complaints related to our privacy practices, you should contact:

Arizona Psychiatry and Neuroscience Institute
2152 S. Vineyard Ave, Bldg. 12, Suite 138
Mesa, Arizona 85210
Phone: (480) 967-6888 Fax: (480) 967-6887

We will supply a written copy of this Notice to any person requesting it, whether or not a current patient. All patients will be given a copy of this Notice at the time of the first service provided to them following the effective date listed above. This Notice will be posted prominently and copies will be made available in our office.

We reserve the right to make changes to our Notice and have any new provisions become effective for all protected health information we maintain. If we make any material changes to the uses or disclosures of protected health information, the individual's rights, our legal duties, or other privacy practices stated in this Notice, this Notice will be revised. The revised Notice will be posted prominently in our office, and we will make the revised Notice available to anyone who requests a copy.

Your Rights as a Patient
With respect to your protected health information, you (or your personal representative, with legal authorization) have certain rights:

1. to obtain a paper copy of this Notice of Privacy Practices for Protected Health Information upon request;
2. to revoke your consents or authorizations;
3. to inspect and obtain a copy of the health information that is used to make individual health care decision about you (so called "designated record sets");
4. to appeal decisions we make regarding denial of access to your records;
5. to request amendments to your health records;
6. to dispute decisions regarding denial of amendment to your records;
7. to request restrictions on certain uses arid disclosures;
8. to request that confidential communications take place by alternative means to alternative locations;
9. To obtain an accounting of disclosures;
10. To lodge a complaint with us or with the Secretary of Health and Human Service if you believe there has been a HIPAA privacy violation, without fear of retaliation, coercion, or intimidation.

Acknowledge of Receipt of this Notice of Privacy Practices
We will make a good faith effort to provide you with a paper copy of this Notice of Privacy Practices and obtain a written acknowledgement from you. If we are unable to obtain such acknowledgement, we will document the reason.

Patient's signature _____ Date _____

PATIENT PAYMENY POLICY

Insurance: We participate in most insurance plans. We bill your insurance company as a courtesy to you. Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility. Please be aware that the balance of the claim is your responsibility whether or not your insurance pays the claim. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Private Pay/ No Insurance: Payment is due at the time of service. Payment will be accepted in the form of cash, debit or credit.

Medicare: Because we accept assignment with Medicare, it is mandatory that we bill your claim directly to Medicare. If you have Medicare only, you are responsible for 20% which is due at the time of service. Federal law requires us to bill you for deductibles and/or co-insurance 20%. Per Medicare guidelines we are unable to waive or write these fees off. Payment is due at the time of service. If you wish to have your secondary insurance billed, please make sure you provide all pertinent information before your visit.

Referrals: If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. If you choose to keep the scheduled appointment without a referral, you will be responsible for full charges to be paid that day and also sign a waiver.

Worker's Compensation: We require written approval/ authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Nonpayment: If your account is past due, you will receive a letter from us stating you have 30 days to pay your account in full. Please be aware that if your balance remains unpaid, we may refer your account to a collections agency. There will be a 35% charge assessed to any account sent to collections. If this occurs, you will not be seen in the office until your balance is paid in full and all charges for future visits will be collected up front.

Returned Checks: There is a fee of $25.00 for any checks returned by the bank.

Missed Appointments: Our policy requires 24 hours' notice to cancel or change an appointment, including TMS appointments, to avoid a $50.00 fee. We understand that emergencies arise. If an emergency prevents you from keeping your appointment, please contact us as soon as possible to reschedule. Please help us serve you better by keeping your scheduled appointments. If you miss 3 consecutive appointments, we may discharge you from the practice for non-compliance.

Arriving late to an appointment: We understand arriving late to an appointment sometimes cannot be helped, however if you are going to be 10 min late please call our office to let us know so we may inform the provider. The provider will make a decision based upon their schedule if we may see you late or not

Medical Record Copies: You will need to request copies of your records in writing. We are happy to email or fax your records to a secured fax free of charge. If you wish to have your records printed, you will be charged a reasonable copying fee of $1 per page. There is also a $5 postage fee if the records are to be mailed.

Patient Name: _____Signature: _____ Date: _____

CONSENT TO RELEASE MEDICAL INFORMATION

Patient's Name: _____

Date of Birth: _____/_____/_____

I hereby authorize: FARIBA PFITZNER, M.D.

and:

Name: _____

Address: _____

Phone: _____

Fax: _____

Authorization for Exchange of Confidential Information

To exchange information about the above named patient's records as they feel appropriate to optimize care.

Authorization for Release of Confidential Information

To release the following:

☐ Evaluation ☐ Psychological Testing ☐ Medical Records/Summary

☐ School Records ☐ Laboratory Studies ☐ Diagnostic Studies

☐ Discharge Summary ☐ Other Pertinent Information

I understand that this consent can be withdrawn by me at any time by written notification except for information already released under this agreement. I also understand that this information cannot be re-released to a third party without a specific consent.

Signature of Patient/Guardian: _____

Date: _____