Arizona Psychiatry and Neuroscience Institute

2152 S. Vineyard Ave, Bldg. 12, Suite 138, Mesa, Arizona 85210
PHONE: (480) 967-6888 EXT:402 ; FAX (480) 967-6887

RETURNING 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 #: _____

MEDICAL HISTORY

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:

_____

_____

_____

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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:

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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: _____