Psychiatric Remedy PLLC
20280 N. 59th Ave, Suite 115-643
Glendale, Arizona, US - 85308-6374

Consent Form & Policies

PATIENT MEDICATION POLICY:

1. Medication refills will be submitted during appointments ONLY.

APPOINTMENT & FINANCIAL RESPONSIBILITY POLICIES:

1. Please provide at least a 24-hour appointment cancellation notice to our office. Failure to do so will result in a $50.00 surcharge for failing to notify Psychiatric Remedy PLLC.

2. Patient DEDUCTIBLES and FEES ARE DUE prior to your follow-up appointment.

3. Follow-up appointments will not be honored if patient has pending deductibles due.

4. In order for Psychiatric Remedy PLLC to fill any FMLA forms, new patients must have at least three documented appointments with the psychiatric provider.

7. Inappropriate language, threats, and/or behavior will not be tolerated, and will be grounds for dismissal from the practice.

I have read, understand, and agree to the policies stated above. My signature is confirmation that I agree to all terms listed in Psychiatric Remedy PLLC's contract.

PATIENT / CARE GIVER SIGNATURE: *

PATIENT INFORMED CONSENT

I have chosen to receive mental health services through Psychiatric Remedy PLLC. My choice has been voluntary, and I understand that I may terminate treatment at any time. I understand that the confidentiality of records or information collected about me will be held and released in accordance with state laws regarding confidentiality of such records and information. I understand state and local law requires all cases in which there exists a danger to self or others to be reported by Psychiatric Remedy PLLC. I have read and understand the above statement.

PATIENT / CARE GIVER SIGNATURE: *

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NOTICE OF PRIVACY PRACTICES TO OUR PATIENTS

This notice describes how your health information may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created because of the Health Insurance Portability and Accountability Ace of 1996 {HIPPA} OUR COMMITMENT TO YOUR PRIVACY our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

PATIENT / CARE GIVER SIGNATURE *

DISCLOSURE OF HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or legal administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

PATIENT / CARE GIVER SIGNATURE: *

PATIENT'S RIGHTS

1. Communication: You can request that our practice communicates with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests made in advance.

2. You can request a restriction in our use or disclosure of your health information for treatment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree: We are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. 3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, medical and billing records, but not including psychotherapy notes. You must submit your request in writing to Psychiatric Remedy PLLC, Attn: Release of Information (ROI) to email: info@premedypllc.com.

4. You may request to amend your health information if you believe it is incorrect or incomplete, and if the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Psychiatric Remedy, Attn: Medical Records to email: info@premedypllc.com.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may request a copy of this notice at any time. To obtain a copy of this notice, your request must be in writing and submitted to Psychiatric Remedy PLLC, Attn: Copy of Notice Documentation to email: info@premedypllc.com.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint in writing. To file a complaint with our practice, contact Psychiatric Remedy PLLC, Attn: Complaint to email: info@premedypllc.com. All complaints must be submitted in writing. You will not be penalized for filing a complaint. I hereby acknowledge that I have been presented with a copy of the Psychiatric Remedy PLLC.

PATIENT / CARE GIVER SIGNATURE: *

PSYCHIATRIC REMEDY PLLC CONTROLLED MEDICATION DRUG POLICY

Psychiatric Remedy PLLC., Drug Policy for controlled medications are controlled for medical and legal purposes ONLY. If prescribed medication is not used properly by the patient, they can cause medical side-effects and problems that could potentially put your health at serious risk. If sold for street use, they contribute to addiction and crime. Our office reserves the right to manage these medications in ways that are medically appropriate and meet all Federal and State Regulations. Psychiatric Remedy PLLC adheres to strict medication prescription regardless of a patient's past medical prescriptions history honored by other providers in from other practices. Please read the following carefully. By signing it, you are agreeing to follow every one of the agreements it contains. Exceptions cannot and will not be made under any circumstances.

1. Controlled substances are habit forming and can cause physical dependence. Suddenly stopping the medication may cause physical withdrawal symptoms. These symptoms may include flu-like feelings, crawling skin, sleeplessness, irritability, anxiety, body aches and pain, and even seizures. I understand that I may develop physical dependence from medication.

2. I understand that patients with a history of substance abuse, including alcohol abuse, are at high risk of relapse by taking certain medications. Patients with a strong family history of substance abuse is also at high risk for potential addiction. I also understand that in case I do develop psychological dependence or addiction on controlled substance, my provider at his discretion will taper me off the addicting prescription or refer me to a detox center. I have notified Psychiatric Remedy PLLC of any

personal or family history of substance abuse, including alcohol abuse.

3. You understand that your medication MAY NOT be taken more than the prescribed amount and time. If your medication is not working, you must contact the office. You cannot take extra medicine under no circumstances. Controlled medications will NEVER be refilled more than 2 days early. If you run out of medication early, you may suffer withdrawal symptoms.

4. I will notify Psychiatric Remedy PLLC, if I receive pain medication, sleeping pills, tranquilizers, or other controlled medications from any other doctors or providers (including emergency room doctors). I understand that I may be dismissed from the practice if I do not notify Psychiatric Remedy PLLC that I have received controlled medications from another source. I also understand that obtaining controlled medications from more than one doctor without notifying all providers who prescribe for me is a felony. The only exception is medication taken during an inpatient hospitalization.

5. To get medication refills, I must be seen in this office at least every 30 days; the visit schedule is at the discretion of provider, but never more than 90 days. I understand it is my responsibility to schedule and keep all appointments. I understand that if I have not been seen in 90 days, no medication can be refilled until I come to the office for an appointment.

6. I understand that I am receiving medications that are at high risk of being stolen. I am responsible for protecting these medications. Psychiatric Remedy cannot replace medications or prescriptions that are lost or stolen, including prescriptions lost in the mail. I also understand that if my medications are stolen, I must file a report with local law enforcement agencies.

7. I understand that selling, trading, or giving medication to another person, including a family member, is illegal.

8. I understand that controlled medication is refilled only at the time of visit and only in the amount as discussed and agreed above, regardless of insurance policy.

9. It is the policy of Psychiatric Remedy PLLC to request urine drug tests on those patients taking controlled medications at any time. Patients are solely responsible for fees of these urine tests. Psychiatric Remedy PLLC will be unable to prescribe medications to any patient who refuses such a test no matter what the reason or circumstances.

10. I give my permission for Psychiatric Remedy PLLC to contact any pharmacy, physician, or hospital to specifically discuss my medications whenever they feel it is necessary. I understand that providers at Psychiatric Remedy PLLC have access and check data on a state prescription drug monitoring program.

11. Most patients are medically capable of driving once they have adjusted to taking their medication on a regular basis. However, laws in most states consider anyone driving while taking sedating medication(s) to be driving under the influence (DUI). In such cases, it does not help or matter if your doctor believes it was safe for you to drive.

PATIENT / CARE GIVER SIGNATURE: *