PATIENT INTAKE FORM

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☑ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By _____ Occupation _____

Home Phone _____ Work/Mobile phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birth date _____ Soc. Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Ins. ID No. _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birth date _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Ins. ID No. _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I understand that I am ultimately responsible for all charges accumulated. I hereby authorize the doctor to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

I give permission for treatment of myself/my dependent to my assigned provider.

_____ _____ _____
Responsible Party Signature Relationship Date

Patient Financial and Fee Agreement

Your insurance will be billed at the following rate. You will be responsible for co-pays, co-insurance, or deductibles as directed by your insurer at the time of service.

SERVICE	FEE
Initial evaluation and diagnostic inventory	$150.00
Individual psychotherapy session	$125.00
Family psychotherapy session	$125.00
Group psychotherapy session	$50.00
Psychological testing (per hour)	$125.00
Court testimony, inc. travel, wait time (per hour)	$175.00
Missed appointment	$75.00
Late cancellation (less than 24 hour notice)	$50.00

Due to insurance carriers' tardiness in regards to service claims submitted by providers, please read the following information:

> If your insurance company does not respond in a timely fashion a "Statement" will be released to you. Upon receipt of the "Statement" we suggest that you contact your insurance carrier and request that they process your claim.
>
> Should you receive any correspondence from your insurance company in regards to your services in this office, **you must respond to that correspondence immediately,** in order to have the claim processed and paid.
>
> Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance at the time of service.

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process my insurance claim.

Insured's or authorized person's signature: I authorize payment of medical benefits to the provider for services. I fully understand that, regardless of insurance coverage, I am legally responsible for all fees due the doctor.

Patient's Signature _____ Date _____

Responsible Party's Signature _____ Date _____

Returned checks will be assessed a $30.00 fee. Please note that unless your appointment is cancelled with a 24-hour notice, late cancellation fees will apply. Delinquent accounts are subject to referral to collection agencies and interest at a rate of 10% per annum will apply for balances over 60 days old. Any questions regarding financial issues may be directed to the Office Manager.

Psychiatric/Medical/Family History

Please answer these questions as best as you can to help facilitate a more thorough evaluation.

PAST PSYCHIATRIC HISTORY

Please check the box that applies.

Seen a psychiatric practitioner	☐ Yes	☐ No	Suicide attempts	☐ Yes	☑ No
Been on psychiatric medications	☐ Yes	☐ No	Alcohol/drug treatment	☐ Yes	☑ No
Counseling	☐ Yes	☐ No	Legal problems	☐ Yes	☑ No
Hospitalization	☐ Yes	☐ No	DUI/DWI conviction	☐ Yes	☑ No

MEDICAL HISTORY

Indicate which of the following you have experienced or are currently experiencing:

☐ Heart surgery/disease/attack	☐ Liver disease (inc. jaundice)	☐ Paralysis, stroke
☐ Severe muscular/skeletal problem	☐ Sexually transmitted disease	☐ Seizure
☐ Diabetes	☐ Currently pregnant	☐ Neurological disorder
☐ Thyroid disease	☐ Currently nursing	☐ Stomach problem
☐ High blood pressure	☐ Bleeding tendencies	☐ Visual impairment
☐ Cancer	☐ Severe respiratory problem	☐ Hearing impairment
☐ Hepatitis	☐ Severe urinary tract problems	☐ Glaucoma

If you checked any of these conditions, or are experiencing others, please indicate the specific nature here:

_____

_____

_____

If you have a family history of these conditions, or similar conditions, please indicate the specific nature here:

_____

_____

_____

CURRENT MEDICAL STATUS

Height: _____ Weight: _____

Please indicate any prescribed and/or over-the-counter medications that you are currently taking.

MEDICATION	DOSAGE (mg)	FREQUENCY	PRESCRIBER

Allergies _____

Have you seen a physician in the past two years? ☐ Yes ☐ No Date of last physical exam: _____

Primary Care Physician _____ Telephone number _____

Problem Inventory

CURRENT PROBLEMS

I am currently experiencing the following problems (please check all that apply)

- ☐ Marital relationship problems
- ☐ Physical abuse
- ☐ Problems on the job
- ☐ Losing someone or something close to me (person, job, pet, moving, etc.)
- ☐ Problems with my children
- ☐ Sexual abuse
- ☐ Current problems from past sexual abuse
- ☐ Alcohol abuse
- ☐ Drug abuse

- ☐ Feeling guilty about past misdeeds
- ☐ Feeling that I am no good
- ☐ Feeling the need to get more sleep
- ☐ Losing pleasure in my daily activities
- ☐ Often feeling restless or irritable
- ☐ Thinking about dying or killing myself
- ☐ Trouble keeping my mind on a task
- ☐ Feeling sad or "down in the dumps"

- ☐ Preoccupied with sexual thoughts or urges
- ☐ Needing less sleep than usual
- ☐ Spending sprees
- ☐ Trouble making myself slow down or talk less

- ☐ Fear of crowds or public places
- ☐ Specific fear of a thing or place
- ☐ Attacks of fearfulness where I feel I need to run
- ☐ Heart palpitations
- ☐ Chest pains or discomfort
- ☐ Feeling dizzy or unsteady
- ☐ Feeling things that aren't there
- ☐ Tingling in hands or feet
- ☐ Hot or cold flashes
- ☐ Trouble breathing
- ☐ Feeling trembly or shaking
- ☐ Fears of dying or going crazy

- ☐ Feeling the urge to avoid certain places or objects
- ☐ Feeling troubled by repetitive thoughts
- ☐ Feeling anxious and nervous
- ☐ Worrying about things over and over

- ☐ Feeling the urge to do something unnecessary
- ☐ Checking, hand washing, hair pulling

- ☐ People following me, out to hurt me, or talking about me
- ☐ People reading my thoughts
- ☐ Hearing voices
- ☐ Thoughts being put into my head, controlling me, making me do things
- ☐ Special messages to me from TV or radio

- ☐ Feeling emotionally "numb"
- ☐ Recurring nightmares
- ☐ Frequently feeling startled
- ☐ Being troubled by painful memories

- ☐ Parts of my body not functioning well
- ☐ Feeling aches and pains all over my body
- ☐ Often feeling sickly
- ☐ Fear of having or getting a disease

- ☐ Problems with my memory
- ☐ Knowing where or who I am
- ☐ Getting lost or confused

- ☐ Having trouble remembering my past
- ☐ Finding things I don't remember having
- ☐ Feeling that I've lost time

- ☐ Urges to do something harmful to myself or others
- ☐ Urges to set fires
- ☐ Difficulty controlling my temper
- ☐ Feeling anger or resentment

- ☐ Taking laxatives to control my weight
- ☐ Vomiting to control my calorie intake
- ☐ Exercising frequently and vigorously
- ☐ Fasting in order to control my weight
- ☐ Feeling helpless about my eating habits
- ☐ Extreme changes in my weight

Any other problems not mentioned above

_____

Notice Of Privacy Practices For Protected Health Information

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

This office is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice. If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for <u>treatment</u> purposes are:

- *A provider or assistant obtains treatment information about you and records it in a health record.*
- *During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will obtain your signed authorization before sharing information with such specialists to obtain his/her input.*
- *Referral information may be forwarded to Diagnostic Testing Labs for further treatment or testing where the provider will want results of such treatment or testing reported bock to him/her.*
- *If the provider is a specialist, your health information and progress may be reported back to your primary care provider or referring provider, upon receipt of your written authorization.*

Example of use of your health information for <u>payment</u> purposes:

- *We submit requests for payment to your health insurance company. The health insurance company requests health information from us regarding medical care given. We will provide information to them about you and the care given. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.*

Example of use of your health information for <u>health care operations</u>:

- *We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.*

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the treating provider. The information in it, however, belongs to you. You have the right to:

- *Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted as required by law:*
- *Obtain a paper copy of the Notice of Privacy Practices for Protected Health information ("Notice") by making a request at our office.*
- *Request that you be allowed to inspect and copy your billing record - you may exercise this right by delivering the request in writing to our office;*
- *Obtain an accounting of disclosures of your health information as required to be maintained by law, upon request. An accounting will not include internal uses of information for treatment, payment, operations, or disclosures made to you; and*
- *Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.*

If you want to exercise any of the above rights, please contact *Kathleen Tierney, 480-775-8811, at 4015 S. McClintock Dr., Suite 112, Tempe, AZ 85282,* in person or in writing, during normal business hours. She will provide you with assistance on the steps to take to exercise your rights.

(continued on back)

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

OUR RESPONSIBILITIES

This office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact *Kathleen Tierney, 480-775-8811.* Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Kathleen Tierney. You may also file a complaint by mailing it to the Secretary of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. Likewise, we cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

OTHER DISCLOSURES AND USES

Notification of Family/Friends: Our office does NOT disclose protected health information or any other information to family members.

Appointment Reminders and Treatment Information: We may contact you and/or leave a message on your telephone answering machine to provide you with appointment reminders, lab results, prescription information, or billing information.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers Compensation.

Abuse, Neglect & Domestic Violence: We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose *to* the institution or law enforcement official health information necessary for your health and safety or the health and safety of other individuals.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime in emergencies; and other appropriate situations as permitted by law.

Judicial/Administrative Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, discovery request or other lawful process if certain specific requirements are met. To avert a serious threat to health or safely, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Other Uses: Any other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Effective Date: June 16, 2004

_____ _____

Signature acknowledging receipt Date

Wendy Hart, Ph.D.
6101 S. Rural Rd., Ste. 103, Tempe AZ 85283
Ph: (480) 775-8811 ♦ Fax (602) 429-8425

AUTHORIZATION FOR EXCHANGE OF INFORMATION

Patient name: _____ Date of Birth: _____

Information about you cannot be exchanged without your consent. Your signature on this release authorizes your provider to obtain or release medical records or information regarding your care. For the purposes hereof, "Medical Records" include all confidential HIV-related information, confidential communicable disease-related information, confidential alcohol or drug-abuse related information, and confidential psychological, behavioral health, medical, and educational data.

This disclosure is for the purpose of diagnosis, treatment planning, follow-up, subpoena for records, coordination of care, employment, and/or any reason listed below:

_____

The following limitations/exceptions to the disclosure of this information apply:

_____

☐ Please release information to:
☐ Please request information from:

Name

Mailing Address

City State Zip Code

Phone Number Fax Number

☐ Please release information to:
☐ Please request information from:

Name

Mailing Address

City State Zip Code

Phone Number Fax Number

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically one year from the date on which it is signed. Any disclosure of medical record information by the recipients is not authorized except when implicit in the purposes of this disclosure.

☐ **I decline this authorization;** I do not wish to have my medical records exchanged.

Signature of client or authorized person Date

Witness Date