JoEllen Butler, PsyNP
8727 S. Priest Dr. Suite #102
Tempe, AZ 85284
Phone: 480-787-9384 **/ Fax:** 480-940-3922
Email: joellenbutlerpsynp@gmail.com

OFFICE HOURS:

Monday – Thursday:	**9:00AM – 5:00PM**
Friday, Saturday, Sunday:	**CLOSED**

Additional office closures can be found online at: JoEllenButlerPSYNP.com

Payment:
Payment can be made by cash, check, debit or credit at the time of your appointment. Please be prepared to pay all charges due at the time of service.

In order to keep our costs down and be able to provide superior customer service in a calm, comfortable environment, JoEllen H. Butler NPPC is strictly a self-pay provider's office. We do not accept insurance of any kind. However, we can provide instructions on how to potentially be reimbursed by your insurance company, if you choose to do so.

Response Time:
We require 24 hours on all returned phone calls/correspondence and prescription refill requests. Monday is our busiest day and we may have a longer than normal response time due to the high volume of requests.

Appointment Reminders:
24 hours prior to your appointment, you will receive a text message reminder. This message is automated and comes from a number that does not accept text messages/phone calls. If you need to cancel or reschedule your appointment, please call or text the office # 480-787-9384.

After Hour Emergency Number – 480-650-3426:
This number is for after business hours emergencies only. Please **do not** call the emergency number for anything other than after hour emergencies. Thank you!

Currently we are NOT taking in-person appointments. ALL appointments are being via Doxy.Me or a phone call.

ADULT PERSONAL HISTORY

DEMOGRAPHICS **Date:** _____

Name: _____

Date of Birth: _____ **Age:** _____ **Gender:** Female ___ Male ___

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email: _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Occupation:** _____

Marital Status: _____ **How did you hear about us?** _____

Emergency Contact:

Name: _____

Relationship: _____ **Phone Number:** _____

PATIENT FINANCIAL AND FEE AGREEMENT

FEES:

Initial Evaluation Intake Appointment – 60 Minutes A $50.00 deposit is due in order to schedule your Initial Appointment and will apply towards the balance due. Refunds will not be granted for no-shows or same day cancellations.	$275.00 - $50.00 deposit $225.00 due day of
Extended Appointment – 30 Minutes	$150.00
Extended Appointment – 60 Minutes	$200.00
Med Management Appointment – 15 Minutes	$90.00
Follow up Phone Appointment – 15 Minutes	$90.00
Missed Appointment Fee	$50.00
Insufficient Funds/Returned Check Fee	$30.00
Letter/Note Fee	$40.00

Important:
- When scheduling- filling out any outside paperwork (FMLA, SSI, Disability, School or anything work related, etc.) requires an extended appointment.

- It is your responsibility as the patient/client to make sure your account is in good standing. You are responsible for all outstanding balances, which will need to be brought current prior to your next appointment or refill request. Please be prepared to take care of all charges, balances and fees at the time of service.

- You understand that you are financially responsible for all charges whether or not you are reimbursed by your insurance company.

AUTHORIZED PERSONS SIGNATURE:

I authorize payment of medical benefits to the supplier for services. I fully understand that I am legally responsible for all fees due to the practitioner regardless of insurance coverage.

_____ _____

Responsible Party's Signature **Date of Birth**

_____ _____

Responsible Party's Printed Name **Date**

AUTHORIZATION:

Information about you cannot be exchanged without your consent. Your signature authorizes JoEllen H. Butler, NPPC to obtain or release your medical records or information regarding your care. This disclosure is for the purpose of diagnosis, treatment planning, follow-up, subpoena for records, coordination of care, employment, and/or any other reason medically necessary.

MISSED APPOINTMENTS / RETURNED CHECKS:

Missed appointments, appointments canceled less than 24 hours in advance are subject to a no show or late cancellation charge. To avoid being charged late cancellation, please call the office as soon as you know that you will not be keeping your appointment, so we can offer it to someone else waiting to be seen.

Missed or late-cancel New Patient Initial Evaluation appointments are subject to a $100.00 charge. To avoid being charged, please call us up to the day before the appointment to cancel or reschedule.

Returned checks will be responsible for a $30.00 fee.

Extended phone calls will be responsible for a $90.00 fee.

All accounts must be kept current and up to date in order to receive refill prescriptions and schedule appointments. It is the patients responsibility to make sure their follow up appointment has been scheduled in order to not run out of medication and that refill requests are submitted during business hours.

There will be a $50.00 fee charged for all No Call / No Shows less than 24 hours in advance or continuous cancellations.

_____ _____

Responsible Party's Signature **Date**

_____ _____

Responsible Party's Printed name **Date of Birth**

MEDICAL HISTORY

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

PAST PSYCHIATRIC HISTORY: Please check the answer 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**

PSYCHIATRIC PERSONAL/FAMILY HISTORY

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

Heart Surgery/Disease/Attack		Heart Surgery		Heart Attack	
Paralysis/Stroke		STD's		Diabetes	
Severe Muscular Problems		Cancer		Neurological Disorder	
Severe Skeletal Problems		Hepatitis		Stomach Problems	
Severe UTI Problems		Thyroid Disease		Glaucoma	
Severe Respiratory Problems		Liver Disease		Hearing Impairment	
Currently Pregnant		Currently Nursing		OTHER	

If you checked any of these conditions or marked "other", 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:	**Dose & Frequency:**	**Side Effects:**	**Prescribed by:**
_____	_____/_____	_____	_____
_____	_____/_____	_____	_____
_____	_____/_____	_____	_____
_____	_____/_____	_____	_____
_____	_____/_____	_____	_____
_____	_____/_____	_____	_____

Allergies:

_____
_____
_____

Have you seen a physician in the past two years? Yes ___ No ___

Date of last physical exam: _____

Primary Care Physician: _____

Office Number: _____ **Fax Number:** _____

Current Therapist: _____

Office Number: _____ **Fax Number:** _____

PROBLEM INVENTORY:

Marital/Relationship Problems		Physical Abuse	
Problems at work		Sexual Abuse	
Problems with my children		Current problems from past sexual abuse	
Losing someone/something close to me		Alcohol or drug abuse	
Trouble keeping my mind on a task		Feeling sad or “down in the dumps”	
Feeling the need to get more sleep		Needing less sleep than normal	
Spending sprees		Trouble making myself slow down/talk less	
Feeling that I am no good		Feeling guilty about past misdeeds	
Preoccupied with sexual thoughts/urges		Losing pleasure in my daily activities	
Often feeling restless or irritable		Thinking about dying or killing myself	
Fear of crowds or public places		Specific fear of a thing or place	
Frequently feeling startled		Attacks of fearfulness where I feel I need to run	
Heart palpitations		Chest pains or discomfort	
Recurring nightmares		Feeling dizzy or unsteady	
Feelings things that aren’t there		Tingling in hands or feet	
Hot or cold flashes		Trouble breathing	
Feeling trembles or shaking		Feeling anxious or nervous	
Feeling “numb”		Feeling the urge to avoid certain places/objects	
Feeling troubled by repetitive thoughts		Worrying about things over and over again	
Being troubled by painful memories		Feeling the urge to do something unnecessary	
Parts of my body not functioning well		Feeling aches/pains all over my body	
Often feeling sickly		Fear of having or getting a disease	
Problems with my memory		Problems knowing where or who I am	
Problems getting lost or confused		Having trouble remember my past	
Finding things I don’t remember having		Feeling that I’ve lost time	
Urges to do something harmful to others		Urges to do something harmful to myself	
Urges to set fires		Difficulty controlling my temper	
Feeling anger or resentment		Checking, hand washing, and/or hair pulling	
Feeling that people are following me		Feeling people are out to hurt me	
Feeling people are talking about me		Feeling people are reading my thoughts	
Feeling that thoughts are being put in my head/controlling me		Feeling that special messages are being sent to me from the TV or radio	
Auditory or visual hallucinations		Taking laxatives to control my weight	
Vomiting to control my calorie intake		Exercising frequently to control my weight	
Feeling helpless about my eating habits		Extreme changes in my weight	

Any other problems not mentioned or additional details regarding selections above:

_____

_____

_____

_____

INSURANCE INFORMATION:

Note – While JoEllen does not accept insurance and is strictly self-pay, your insurance information is necessary in case a prior authorization is needed for medication prescribed. While we are able to provide assistance with prior authorizations, we are entitled to discontinue providing assistant at any time, for any reason.

Please provide a copy of your insurance card and driver's license by email (joellenbutlerpsynp@gmail.com) or text message (480-787-9384)

Insurance Company: _____

ID Number: _____ **RX BIN #:** _____

Phone Number: _____

PHARMACY INFORMATION:

It is your responsibility to notify the office if your pharmacy has changed. Before contacting the office for a refill, please contact your pharmacy and speak with a pharmacist directly to verify if a refill is already on file.

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ **State:** _____ **Zip:** _____

Pharmacy Phone Number: _____

Store Number (this is different than the phone number)**:** _____

Use/Disclosure of 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 THIS NOTICE CAREFULLY.

-Your health record contains personal information about you and your health: This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

-We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

-For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

-For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

-For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

-Required by Law: Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

-Without Authorization: Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

-Child Abuse or Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

-Judicial and Administrative Proceedings: We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

-Deceased Patients: We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

-Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

-Family Involvement in Care: We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

-Health Oversight: If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

-Law Enforcement: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or

missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

-Specialized Government Function: We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

-Public Health: If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

-Public Safety: We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

-Research: PHI may only be disclosed after a special approval process or with your authorization.
-With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

RIGHTS REGARDING YOUR PHI

-Right of Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

-Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

-Right to an Accounting of Disclosures: You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
-Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

-Right to Request Confidential Communication: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

-Breach Notification: If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

-Right to a Copy of this Notice: You have the right to a copy of this notice. Please contact the office you wish to receive a copy.

The effective date of this Notice is September 2020

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Printed Name of Patient or Legal Guardian **DOB**

Patient Consent for Use/Disclosure of Protected Health Information

Patient Name: _____ **DOB**: _____

I understand that my health information is private and confidential. I understand that the office of JoEllen Butler NPPC works hard to protect my privacy and preserve the confidentiality of my health information.

I understand the office of JoEllen Butler NPPC may use and disclose my health information to provide treatment to me, to handle billing and payment, and to take care of other healthcare operations. (In general, there will be no other uses and disclosures of this information unless I permit it) I understand that sometimes the law may require the release of information without my permission. These situations are very unusual. One example would be if a patient threatened harm to someone or one's self.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing and dating a form that the office of JoEllen Butler NPPC can give me called "Revocation of Consent for use and disclosure of healthcare information" or
2. By writing, signing and dating a letter to the office of JoEllen Butler NPPC. If I write the letter it must say, "I revoke my health information for treatment, payment, and healthcare operations."

I understand that if I revoke this consent, the office of JoEllen Butler NPPC does not have to provide any further health care services to me.

My signature below indicates that I agree and consent to allow the office of JoEllen Butler NPPC to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. I also understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.

_____

Signature of Patient or Legal Guardian

_____ _____

Printed Name of Patient or Legal Guardian **Date**

GENERAL PATIENT CONSENT FOR CARE FORM:

General Consent to Care: I, the undersigned, for myself or a minor child or another person for whom I have authority to sign for, hereby consent to medical care and treatment, as ordered by JoEllen H. Butler, PsyNP.

I agree and acknowledge that JoEllen H. Butler is not liable for the actions or omissions of, or the instructions given for treatment while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments by JoEllen H. Butler.

To the Patient: You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any medication ordered for you. If you have any concerns regarding treatment recommended by JoEllen H. Butler, we encourage you to ask questions. 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(s) recommended; and (2) you consent to treatment provided by JoEllen H. Butler. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Printed Name of Patient or Legal Guardian **DOB**