JoEllen H. Butler, PsyNP
New Patient Paperwork

Phone: 480-787-9384 | Fax: 480-940-3922
joellenbutlerpsynp@gmail.com
www.joellenbutlerpsynp.com

Patient Information Date: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital status: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Employment status: _____ Employer: _____

Referred by: _____

Emergency

Emergency contact/Name: _____

Relationship to Patient: _____ Phone: _____

☐ I authorize this office to contact the above individual in case of emergency and to disclose relevant information necessary for my safety.

Reason for visit:
Please briefly describe the reason for your visit, or what you're hoping to address.

Patient Name/First: _____ Last: _____ DOB: _____

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 directly and speak with a staff member to confirm whether refills are already on file.

Pharmacy name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Insurance Information

While JoEllen does not accept insurance and services are strictly self-pay; your insurance information may be required in the event a prior authorization is needed for a prescribed medication. Submission of a prior authorization does not guarantee approval.

Primary Insurance Company Name: _____

Member/Policy ID: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Subscriber: _____

RxBIN: _____ RxPCN: _____ RxGRP: _____

Secondary Insurance Company Name: _____

Member/Policy ID: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Subscriber: _____

RxBIN: _____ RxPCN: _____ RxGRP: _____

Patient Name/First: _____ Last: _____ DOB: _____

Medical Information

Height: _____ Weight: _____ Date of last physical exam: _____

Current Medical Providers

Type	Provider Name	Phone #	Specialty, or condition treated
PCP			
Therapist			
Other			
Other			
Other			

Medication

Allergies or intolerances to medication

Name	Dose	Frequency	Reaction

CURRENT: List ALL medications you are currently taking (include all herbals, vitamins & supplements)

Name	Dose	Frequency	Reaction

PAST: List any additional past/attempted/failed medications

Name	Dose	Frequency	Reaction

Additional Information (optional):

Patient Name/First: _____ Last: _____ DOB: _____

History

Past Psychiatric History: Please check all answers that apply.

- ☐ Seen a psychiatric practitioner
- ☐ Been on psychiatric medications
- ☐ Counseling/Therapy/Group
- ☐ Hospitalization
- ☐ Suicide Attempt(s)
- ☐ Legal Problems
- ☐ DUI/DWI Conviction
- ☐ Alcohol Treatment
- ☐ Drug Treatment
- ☐ Other _____

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

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

If you checked any of these conditions or marked “other”, indicate the specific nature here:

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

Additional Information (optional):

Patient Name/First: _____ Last: _____ DOB: _____

Problem Inventory

- ☐ 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 misdeed
- ☐ 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 or a thing or a 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 drying or going crazy

- ☐ Feeling the urge to avoid certain places or objects
- ☐ Feeling troubled by repetitive thoughts
- ☐ Feeling anxious or 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 in 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 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

Other(s):

Patient Name/First: _____ Last: _____ DOB: _____

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.		Never	Rarely	Sometimes	Often	Very Often
1.	How often do you have trouble wrapping up the final details of a project once the challenging parts have been done?					
2.	How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3.	How often do you have problems remembering appointments or obligations?					
4.	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5.	How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6.	How often do you feel overly active and compelled to do things, like you were driven by a motor?					
						Part A
7.	How often do you make careless mistakes when you have to work on a boring or difficult project?					
8.	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9.	How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10.	How often do you misplace or have difficulty finding things at home or at work?					
11.	How often are you distracted by activity or noise around you?					
12.	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13.	How often do you feel restless or fidgety?					
14.	How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15.	How often do you find yourself talking too much when you are in social situations?					
16.	When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17.	How often do you have difficulty waiting your turn in situations when turn taking is required?					
18.	How often do you interrupt others when they are busy?					
						Part B

Adapted from Schweitzer et al. (2001), American Psychiatric Association DSM-IV-TR (2000), Biederman et al. (1993), and Barkley (1998).

Patient Name/First: _____ Last: _____ DOB: _____

BPD (MSI-BPD) MacLean Screening Instrument

Instructions: Please answer the following questions to the best of your ability.		**Yes**	**No**
1.	Have any of your closest relationships been troubled by a lot of arguments or repeated breakups?	☐	☐
2.	Have you deliberately hurt yourself physically (e.g. punched yourself, cut yourself, burned yourself)? How about made a suicide attempt?	☐	☐
3.	Have you had at least two other problems with impulsivity (e.g. eating binges and spending sprees, drinking too much and verbal outbursts)?	☐	☐
4.	Have you been extremely moody?	☐	☐
5.	Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner?	☐	☐
6.	Have you often been distrustful of other people?	☐	☐
7.	Have you frequently felt unreal or as if things around you were unreal?	☐	☐
8.	Have you chronically felt empty?	☐	☐
9.	Have you often felt that you had no idea of who you are or that you have no identity?	☐	☐
10.	Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)?	☐	☐

Zanarini, M. C., Vujanovic, A. A., Parachini, E. A., Boulanger, J. L., Frankenburg, F. R., & Hennen, J. (2003). A screening measure for BPD: the Mclean Screening Instrument for Borderline Personality Disorder (MSI-BPD). Journal of Personality Disorders, 17(6), 568-573. https://doi.org/10.1521 /pedi.17 .6.568.25355

Patient Name/First: _____ Last: _____ DOB: _____

GAD - 7

Over the last 2 weeks, how often have you been bothered by the following problems?

	Place check mark (✓) in correct column.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1.	Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
2.	Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
3.	Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
4.	Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
5.	Being so restless that it is hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
6.	Becoming easily annoyed or irritable	☐ 0	☐ 1	☐ 2	☐ 3
7.	Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
	(For office coding: Total Score T _____ =	**_____ +**		**_____ +**	**_____)**

Developed by Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke, and colleagues, with an education grant from Pfizer, Inc.

Patient Name/First: _____ Last: _____ DOB: _____

MDQ

Instructions: Select the answer (yes or no) that best applies to you.

Please answer each question as best you can.	Yes	No
1. Has there ever been a period of time when you were not your usual self and…	☐	☐
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
…you were so irritable that you shouted at people or started fights or arguments?	☐	☐
…you felt much more self-confident than usual?	☐	☐
…you got much less sleep than usual and found you didn't really miss it?	☐	☐
…you were much more talkative or spoke faster than usual?	☐	☐
…thoughts raced through your head, or you couldn't slow your mind down?	☐	☐
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
…you had much more energy than usual?	☐	☐
…you were much more active or did many more things than usual?	☐	☐
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
…you were much more interested in sex than usual?	☐	☐
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
…spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem		
4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

Adapted from Hirschfeld R. Williams J, Spitzer RL. et al. *Am J Psychiatry* 2000;1571873-1875.

Patient Name/First: _____ Last: _____ DOB: _____

PCL-5: PTSD Checklist for DSM-5

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then place a check mark (✓) in the column to indicate how much you have been bothered by that problem in the past month.

#	In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1	Repeated, disturbing, and unwanted memories of the stressful experience?	☐	☐	☐	☐	☐
2	Repeated, disturbing dreams of the stressful experience?	☐	☐	☐	☐	☐
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	☐	☐	☐	☐	☐
4	Feeling very upset when something reminded you of the stressful experience?	☐	☐	☐	☐	☐
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	☐	☐	☐	☐	☐
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	☐	☐	☐	☐	☐
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	☐	☐	☐	☐	☐
8	Trouble remembering important parts of the stressful experience?	☐	☐	☐	☐	☐
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	☐	☐	☐	☐	☐
10	Blaming yourself or someone else for the stressful experience or what happened after it?	☐	☐	☐	☐	☐
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐	☐	☐	☐	☐
12	Loss of interest in activities that you used to enjoy?	☐	☐	☐	☐	☐
13	Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	☐	☐	☐	☐	☐
15	Irritable behavior, angry outbursts, or acting aggressively?	☐	☐	☐	☐	☐
16	Taking too many risks or doing things that could cause you harm?	☐	☐	☐	☐	☐
17	Being “super alert” or watchful or on guard?	☐	☐	☐	☐	☐
18	Feeling jumpy or easily startled?	☐	☐	☐	☐	☐
19	Having difficulty concentrating?	☐	☐	☐	☐	☐
20	Trouble falling or staying asleep?	☐	☐	☐	☐	☐

Developer Reference: Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013).The PTSD Checklist for DSM-5 (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov.

Patient Name/First: _____ Last: _____ DOB: _____

SDS - Zung Self-Rating Depression Scale

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days

	Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most of the time
1.	I feel down-hearted and blue.	☐	☐	☐	☐
2.	Morning is when I feel the best.	☐	☐	☐	☐
3.	I have crying spells or feel like it.	☐	☐	☐	☐
4.	I have trouble sleeping at night.	☐	☐	☐	☐
5.	I eat as much as I used to	☐	☐	☐	☐
6.	I still enjoy sex.	☐	☐	☐	☐
7.	I notice that I am losing weight.	☐	☐	☐	☐
8.	I have trouble with constipation.	☐	☐	☐	☐
9.	My heart beats faster than usual.	☐	☐	☐	☐
10.	I get tired for no reason.	☐	☐	☐	☐
11.	My mind is as clear as it used to be.	☐	☐	☐	☐
12.	I find it easy to do the things I used to.	☐	☐	☐	☐
13.	I am restless and can't keep still.	☐	☐	☐	☐
14.	I feel hopeful about the future.	☐	☐	☐	☐
15.	I am more irritable than usual.	☐	☐	☐	☐
16.	I find it easy to make decisions.	☐	☐	☐	☐
17.	I feel that I am useful and needed.	☐	☐	☐	☐
18.	My life is pretty full.	☐	☐	☐	☐
19.	I feel that others would be better off if I were dead.	☐	☐	☐	☐
20.	I still enjoy the things I used to do.	☐	☐	☐	☐

William WK Zung. *A Self-Rating Depression Scale*. 12: Arch Gen Psychiatry 63-70. 1965.

Patient Name/First: _____ Last: _____ DOB: _____

Office Information

Office Hours
Monday – Thursday: 9:00 AM – 5:00 PM
Our office is closed for lunch daily from **12:00 PM – 1:00 PM**
Friday – Sunday: Closed

Holidays & Closures
The office is closed on major holidays. Any additional closures will be communicated in advance when possible and can be found on our website at: joellenbutlerpsynp.com

After-Hours Communication
Messages received outside of business hours will be addressed on the next business day.

Response Times
Please allow up to 1–2 business days for responses to routine calls, messages, and refill requests. Monday is our busiest day, and response times may be longer than usual due to a higher volume of requests.

Provider Delays
On occasion, your provider may be running behind schedule, most often due to circumstances with a prior patient's appointment. Please allow up to a 15-minute grace period past your scheduled start time.

Emergency Services
This practice does not provide emergency or crisis services. In a medical or psychiatric emergency, call 911 or go to the nearest emergency room. For a mental health crisis, you can also contact the 988 Suicide & Crisis Lifeline.

After-Hours Emergency Number – 480-650-3426
This number is for after-hours emergencies only. Please do not use this line for non-urgent matters.

Non-Urgent Requests
All non-urgent requests, including appointment scheduling, prescription refills, questions, and messages for JoEllen, should be directed to the office line by phone or text at 480-787-9384. During business hours, this is also the correct line for urgent matters. The after-hour emergency line is reserved strictly for emergencies; non-emergency messages sent to that line during and after business hours may not receive a response. To avoid mixing up the two numbers, please save each as a separate contact (e.g., "JoEllen Butler – Office" and "JoEllen Butler – Emergency Line").

Closure of Care
Patients who have not been seen in 12 or more months may be administratively closed out of care. If you wish to resume care after this occurs, please contact the office. Care may also be discontinued for cause, including, but not limited to: repeated missed appointments or late cancellations, inability to resolve outstanding balances, non-compliance with an agreed treatment plan or medication terms, or inappropriate behavior toward staff.

Appointment Reminders
You will receive a text message reminder 24 hours prior to your appointment. This message is automated and comes from a number that does not accept incoming calls or text messages. **Do not reply to or call this number.** If you need to cancel or reschedule your appointment, please call or text the office at 480-787-9384.

Patient Name/First: _____ Last: _____ DOB: _____

General Consent for Care

I, on my own behalf, or on behalf of a minor child or another individual for whom I am legally authorized to provide consent, hereby consent to psychiatric evaluation, treatment, and care provided by JoEllen H. Butler, PsyNP, and associated staff.

Scope of Practice
As a licensed Nurse Practitioner in the State of Arizona, JoEllen H. Butler practices with full practice authority, meaning she may independently evaluate, diagnose, treat, and prescribe medications, including controlled substances where appropriate, without physician supervision or collaboration, consistent with Arizona law.

Practice Model
JoEllen H. Butler, NPPC is a private-pay, telehealth-only psychiatric practice, and does not accept insurance or maintain affiliation with any hospital system or physician group.

I understand that psychiatric care, like all areas of health care, is not an exact science, and that no specific outcome or result has been guaranteed to me regarding any evaluation, treatment, or medication provided. 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 understand that I have the right to discuss my treatment plan, including the purpose, potential risks, and benefits of any recommended treatment or medication, and I am encouraged to ask questions regarding any aspect of my care at any time. If I have questions or concerns about the care I have received, I am encouraged to discuss them with the office at 480-787-9384.

By signing below, I acknowledge and agree that:

1. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.
2. This consent applies on an ongoing basis throughout my course of treatment, including after a specific diagnosis has been made or treatment has been recommended.
3. I consent to the evaluation, treatment, and services provided by JoEllen H. Butler, PsyNP.
4. This consent remains in effect until I revoke it in writing.
5. I have the right to discontinue treatment at any time.
6. I agree that a photocopy or electronic copy of this signed consent is as valid as the original.

_____ _____

Printed Name of Patient or Legal Guardian Date

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient (if applicable)

Patient Name/First: _____ Last: _____ DOB: _____

Telehealth Informed Consent

JoEllen H. Butler, NPPC provides all psychiatric evaluation and treatment services via telehealth (secure video/audio). Before receiving care, please review and sign this consent.

What Telehealth Is

Telehealth allows your provider to evaluate, diagnose, and treat you remotely using secure video and/or audio technology, rather than in person.

Patient Location

You must be physically located in a state where JoEllen H. Butler is licensed or authorized to practice at the time of each visit. You are responsible for confirming and disclosing your location at the start of every appointment. Care may need to be rescheduled or discontinued if you are located outside an authorized jurisdiction.

Benefits and Risks

Telehealth offers convenience and access to care without travel. Risks include the possibility of technical failures (dropped connections, audio/video interruptions), limitations in the provider's ability to conduct a physical exam, and the general risks inherent to any psychiatric evaluation or treatment, whether in-person or remote.

Confidentiality

You are entitled to the same confidentiality protections in telehealth visits as in-person visits. Please ensure you are in a private location for your appointment, as the practice cannot control who may be present or listening on your end of the call.

Emergencies

Telehealth is not appropriate for medical or psychiatric emergencies. If you are experiencing a crisis, including thoughts of harming yourself or others, call 911, go to the nearest emergency room, or contact the 988 Suicide & Crisis Lifeline. Your provider may not be immediately reachable outside of scheduled appointments, and for your safety may need to contact your designated emergency contact if a crisis or need for a higher level of care arises.

Technology

You are responsible for having a private space, a stable internet connection, and a compatible device for your visit. If a technical failure interrupts your session, your provider will attempt to reconnect or reschedule as needed.

Voluntary Participation

Your consent to telehealth is voluntary. You may withdraw consent at any time by notifying our office, with the understanding that doing so may mean you will need to seek care elsewhere if this practice is not able to offer an in-person alternative.

Consent

I have read and understand the information above. I consent to receive psychiatric evaluation and treatment services via telehealth from JoEllen H. Butler, PsyNP.

_____ _____

Printed Name of Patient or Legal Guardian Date

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient (if applicable)

Patient Name/First: _____ Last: _____ DOB: _____

Notice of Privacy Practices

Acknowledgement of Receipt

I acknowledge that I have been offered and have received, or had the opportunity to receive, a copy of the Notice of Privacy Practices for the office of JoEllen H. Butler, NPPC. The Notice of Privacy Practices describes how my Protected Health Information (PHI) may be used and disclosed, and how I may access that information.

Version received – Effective Date: September 2020 | Last Revised July 2026

I understand that:

1. The office of JoEllen H. Butler NPPC is required by law to protect the privacy of my health information and to provide me with notice of its privacy practices.
2. I have the right to review the Notice of Privacy Practices prior to signing this form. A current version is available upon request and on the practice website.
3. The Notice of Privacy Practices may be updated from time to time. Updated versions will be made available on the practice website and upon request.

If you have any questions regarding this acknowledgment or the Notice of Privacy Practices, please contact our office prior to signing.

_____ _____

Printed Name of Patient or Legal Guardian Date

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient (if applicable)

Patient Name/First: _____ Last: _____ DOB: _____

Controlled Substance Agreement

This agreement applies if JoEllen H. Butler, PsyNP prescribes a controlled substance (including but not limited to stimulants, benzodiazepines, or other Schedule II–V medications) as part of your treatment. Please read carefully.

Purpose

Controlled substances can be an appropriate and effective part of psychiatric treatment, but they also carry risk of misuse, dependence, and diversion. This agreement helps ensure your medication is used safely and as prescribed.

Prescription Monitoring

Arizona law requires your provider to check the state's Controlled Substances Prescription Monitoring Program (CSPMP) database before prescribing certain controlled substances, and periodically throughout treatment. This is a routine part of safe prescribing and applies to all patients receiving these medications, not just you specifically.

Your Responsibilities

By agreeing to this, you agree to:

1. Take medication only as prescribed, and not alter the dose or frequency without discussing it with your provider first
2. Use one pharmacy for all controlled substance prescriptions, and notify our office if you need to change pharmacies
3. Not obtain controlled substances or similar medications from any other prescriber without informing this office
4. Store medication securely and not share, sell, or give it to anyone else
5. Notify our office promptly if medication is lost or stolen (a police report may be requested; lost or stolen medication may not be replaced early)
6. Attend scheduled follow-up appointments as required to continue receiving refills

Refills

Please plan ahead and request refills before you run out. Refill requests are typically processed within 1-2 business days and are not guaranteed same-day. Early refills are granted only at the provider's discretion. Running out early regularly may result in a reassessment of your treatment plan.

Random Screening

Your provider may request a urine drug screen or pill count at any time during treatment as part of routine monitoring. Declining a requested screening may affect your provider's ability to continue prescribing.

Prescribing Limitations

Certain controlled substances (including some Schedule II medications) may require an in-person evaluation under federal and state law, regardless of this practice's telehealth model. Your provider will let you know if this applies to your treatment.

Reasons Treatment May Be Discontinued

Your provider may stop prescribing controlled substances, and may end the treatment relationship, if you: obtain controlled substances from another provider without disclosure, use medication in a way inconsistent with how it was prescribed, test positive for a substance not prescribed to you, or repeatedly miss appointments needed to safely continue prescribing.

Acknowledgment

I have read and understand this agreement. I agree to follow these terms as a condition of receiving controlled substance prescriptions from this practice.

_____ _____

Printed Name of Patient or Legal Guardian Date

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient (if applicable)

Patient Name/First: _____ Last: _____ DOB: _____

Patient Financial and Fee Agreement

Fees reflect the time reserved for your appointment, including chart review, documentation, and care coordination before, during, and after your visit, not just the visit itself. Fees are subject to change; patients will be notified in advance when applicable.

SERVICE	FEE
Initial Evaluation – 60 minutes	$295.00
Medication Management / Follow-up ~ 20 minutes	$120.00
Extended – 60 minutes	$295.00
Extended – 30 minutes	$170.00
Paperwork / Forms – 30 minutes	$170.00
Missed Appointment Fee	$50.00
Letter / Note Fee (outside of appointment)	$50.00

Following the initial visit, patients typically attend Medication Management / Follow-up visits on a recurring basis, with frequency determined by clinical need (typically 1-3 months once established and stabilized).

Important

- JoEllen H. Butler, NPPC is a private-pay practice and is not contracted with insurance plans. Payment is due at the time services are rendered unless prior arrangements have been made.
- Patients are financially responsible for all charges associated with services provided, including appointment fees, missed appointment fees, paperwork fees, and outstanding balances. Patients may request a superbill for possible out-of-network reimbursement; reimbursement is not guaranteed.
- Paperwork requests (including FMLA, disability, SSI, school, work-related forms, and similar documentation) require a scheduled 30-minute, extended appointment. Additional fees may apply based on complexity and time required.
- Accounts must remain in good standing. Outstanding balances may need to be resolved prior to future appointments, prescription refills, or completion of forms.
- Appointments cancelled with less than 24 hours' notice may be subject to a late cancellation fee. Repeated missed appointments or cancellations may result in dismissal from the practice.

Financial Responsibility Acknowledgement

I acknowledge that I have reviewed and understand the Patient Financial and Fee Agreement Policy. I understand that JoEllen H. Butler, NPPC is a private-pay practice and that I am financially responsible for all charges associated with services rendered.

_____ _____

Printed Name of Patient or Legal Guardian Date

_____ _____

Signature of Patient or Legal Guardian Relationship to Patient (if applicable)

Patient Name/First: _____ Last: _____ DOB: _____

Payment Information

Card information provided on this page is used solely to securely save your card with our payment processor. Once securely saved, this page, including the card number and CVV, is deleted from our records.

Debit/Credit Card Information				
Card Type	☐ Mastercard	☐ Visa	☐ Discover	☐ AMEX
	☐ Other _____			
Cardholder Name (as shown on card): _____				
Card Number: _____				
Expiration Date (mm/yyyy): _____		CVV (3-4 digit security code): _____		
Cardholder ZIP Code (from the cardholder's billing address): _____				

Card Verification:

As part of securely saving your card on file, our payment processor (Clover) verifies your card details and ZIP Code to confirm the card is valid and prevent fraud. This involves a temporary $1.00 authorization hold, which will drop automatically within a few days.

Please Note:

Once you have completed this form, Adobe Sign will send you a confirmation email. Simply click "Confirm my email address" to verify your signature. The completed form will then be automatically forwarded to our office.

Important:

For your security, this form is password protected. The password is kept on file by our office and will not be shared with you or any other signer.

Patient Name/First: _____ Last: _____ DOB: _____

Payment Authorization

This page is retained in your patient record. It does not contain your full card number or CVV.

Card on File **Completed by office staff after the card is securely saved*
Card ending in: _____
Cardholder Name: _____

Charges are processed manually by office staff through our payment processor on the day of your appointment, prior to your session, unless another arrangement has been agreed upon.

Retention & Renewal

This authorization remains in effect for as long as you are an active patient of this practice and will be kept on file until you revoke it in writing or your card on file expires. If your card expires or is replaced, you will be asked to complete new Payment Information/Authorization forms. We may periodically ask you to reconfirm this authorization, such as after an extended lapse in treatment.

Authorization

I, _____ (cardholder name), authorize the office of JoEllen H. Butler to retain my payment information above and to charge my debit/credit card at the time of service for all applicable fees related to services provided, in accordance with the practice's published fee schedule. These charges may include but are not limited to: Appointment fees and No-show and late / continuous cancellation fees ($50.00).

This authorization covers services rendered to:

Patient Name: _____ ☐ Same as cardholder

Email (for receipts): _____

Please Note: receipts will be sent to the email address above and will include the charge amount and the name, “JoEllen H. Butler NPPC.” Please keep this in mind if you share this email account or receive statements others may see.

Acknowledgements

1. I certify that I am an authorized user of this credit card, and that I will not dispute the payment with my debit/credit card company, so long as the transaction corresponds to the terms indicated in this form.
2. I understand that I may remove my card on file at any time by submitting a written request to the office.
3. I understand that in the event of a declined charge, I will be contacted promptly and remain responsible for the outstanding balance.
4. I have read and agree to the practice's cancellation and no-show fee policy.

_____ _____

Signature of Cardholder / Responsible Party Date