CHILD AND ADOLESCENT REGISTRATION PACKET

TOTAL PAGES: 12

Please fill out Pages 1-5.

Please retain the rest of the pages for you records.

Please contact for any questions.

Valley Family Psychiatry, PLLC

NirajaT. Patel, D.O. **Phone: (480) 939-3339**
9821 E Bell Road, Suite #100; Scottsdale, AZ 85260 **FAX: (480) 718-9519**

CHILD/ADOLESCENT PATIENT INFORMATION SHEET

Patient's Name:_____ Male_____ Female

Date of Birth:_____ Age:_____ Social Security Number: _____

Parent #1 Name:_____

Date of Birth:_____ Age:_____ Social Security Number: _____

Parent #2 Name:_____

Date of Birth:_____ Age:_____ Social Security Number: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Telephone numbers 1) Please check preferred contact number
2) Initial if you authorize me to leave messages at that number

Parent#1	Parent#2
□____ Home: _____	□____ Home: _____
□____ Cell: _____	□____ Cell: _____
□____ Email: _____	□____ Email: _____

Emergency contact: _____ Relationship: _____

Phone #: _____

Responsible Party: _____ Phone #:_____
Address (if different from above): _____

Referral Source: _____ Phone #:_____
I give Dr. Patel permission to speak with:
Parent:_____ DOB:_____
Parent:_____ DOB:_____
Other:_____ DOB:_____

Pharmacy Name and Address:

Parent #1 Occupation: _____

Parent #1 Current Employer: _____

Parent #2 Occupation: _____

Parent #2 Current Employer: _____

Currently who lives in your home: _____

_____

GENERAL HEALTH:

Current Health Conditions:

_____

_____

Current Medications:

_____

Main Concerns to Address at this appointment:

_____

_____

_____

What are your child's strengths:

_____

_____

_____

Responsible Party's Signature: _____ Date: _____

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DISCLOSURE STATEMENTS

Initials

_____ **PATIENT INFORMATION**
I have received and read a copy of the brochure entitled "Your Psychiatric Care"

_____ **NOTICE OF PRIVACY PRACTICES**
I have received a copy of the Notice of Privacy Practices of Niraja T. Patel, D.O.

_____ **CONFIDENTIALITY**
I understand that all information between my doctor and myself is held strictly confidential, and my doctor will not release any information about my treatment unless permitted by law or:

1. I agree in writing to permit such a release
2. I present a physical danger to myself
3. I present a danger to others
4. Child/elder abuse/neglect is *suspected*

_____ **RELEASE OF INFORMATION**
I authorize discussion of my case with the referral source for purposes of diagnosis and treatment.

_____ **PAYMENT**
I understand that if an appointment is missed or cancelled less than 24 hours in advance, I will be charged at the full rate of my scheduled appointment. Fees are based upon the length of appointment time. Full payment is due at the time of each appointment. Extended phone calls over 5 minutes may be billed. Accounts not paid on a timely basis will be sent to a collection agency. There will be a $25.00 service fee for all returned checks.

Initial Evaluation (Up to 80 minute visit)	$650.00 (up to)
50 minute visit	$360.00
25 minute visit	$180.00

_____ **INSURANCE BILLING**
I understand Dr. Patel will NOT bill insurance companies for outpatient services. I will be given a receipt at the time of the session to submit to my insurance company. Insurance companies require a diagnosis selected from the Diagnostic and Statistical Manual of Mental Disorders.

Patient's Signature:_____ Date:_____

Valley Family Psychiatry, PLLC
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Scottsdale, AZ 85260
Phone: (480) 939-3339
FAX: (480) 361-1919

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Patient Name:_____Date of Birth:_____

I request and authorize Dr. Patel to obtain information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and /or medical records by means of mail, fax, or other electronic methods to:

Name of person/facility to give information:_____

If facility, then specify name of person:_____

Address:_____

City:_____State:_____Zip Code:_____

Phone #:_____FAX:_____

This authorization is:
____Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/treatment)
____Limited to the following medical information:_____

Please initial to specifically authorize the use and/or disclosure of:
____Psychiatric/Mental Health
____Drug/Alcohol/Substance Abuse
____Tests for Antibodies to HIV
____HIV Diagnosis/Treatment

Specify the date or time period for information selected above:_____

Purpose(s) of this use/disclosure:
____Continuity of care or discharge planning
____At the request of patient/patient representative
____Other (state reason)_____

Unless otherwise revoked, this authorization expires: _____(date or event)
If no date is indicated, this authorization will expire 12 months after the date of signing of this form.

-I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Dr. Patel.
-I understand that Dr. Patel may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.
-I understand that if I authorized the disclosure of health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal privacy regulations.
-I understand I am entitled to receive a copy of this Authorization.

Patient's/Authorized Representative's Signature:_____
Print Name:_____Date:_____
Relationship/authority (if signed by authorized representative):_____

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www.valleyfamilypsychiatry.com

CREDIT CARD AUTHORIZATION

Please complete the following information:

I, _____ (*print name)*, am authorizing Valley Family Psychiatry, PLC to Charge my credit card in the event that I fail to show for a scheduled appointment as given to me by Dr. Patel or do not notify Dr. Patel of my inability to attend the scheduled appointment at least 24 business hours in advance, as agreed in our disclosure statement form that I filled out.

By signing, I agree to payment of my participating treatment either in person or by phone (if indicated). I have read, understood and agreed to the terms below:

SIGNATURE: _____

-There will be a charge for all appointments, including No Shows AND canceled appointments less than 24 hours in advance.
-I will not dispute charges for sessions that I have received or that I have canceled less than 24 hours in advance.
-I further authorize Dr. Patel to disclose information about my attendance/cancellation to my credit card company if I dispute the charge.

__ Please check here if authorizing Dr. Patel to use this CC for ongoing visits and treatment.

Card Type (circle one): _Visa _MasterCard _Discover _ American Express
Card #:_____
Expiration Date:_____
Name on Card:_____
Verification/Security Code:_____
Billing Address:_____
(Street, City, State & Zip)

Signature: _____
Date: _____
(*client or financially responsible party)*
This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment (eg. appointment or phone session) without payment rendered.

Parent's/Guardian's Signature:_____ Date:_____

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9821 E Bell Road, Suite #100; Scottsdale, AZ 85260
Phone: (480) 939-3339
Fax: (480) 718-9519

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- Follow the terms of our Notice currently in effect.

II. Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person: Niraja T. Patel, D.O., 9821 E. Bell Road, Suite 100, Scottsdale, AZ 85260, (480) 939-3339.

III. Uses and Disclosures of Information

Under federal and state law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information.

Example of using or disclosing health information for treatment:

- A nurse takes your pulse and blood pressure, records it in the medical record, and informs your doctor of the results.

Example of using or disclosing health information for payment:

- We submit a bill to your health insurer to receive payment for your care; the insurer asks for health information (for example, your diagnosis and what care we provided) in order to pay us. In such situations, we will disclose only the minimum amount of information necessary for this purpose.

Example of using or disclosing health information for health care operations:

- In the course of providing treatment to patients, we perform certain important functions such as quality assessment, training programs, credentialing, medical review, etc. In performing such functions, we may rely on certain business associates to assist us. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

IV. Other Uses and Disclosures

In addition to uses and disclosures related to treatment, payment, and health care operations, we may also use and disclose your personal information without authorization for the following additional purposes:

Abuse, Neglect, or Domestic Violence

- As required or permitted by law, we may disclose health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Appointment Reminders and Other Health Services

- We may use or disclose your health information to remind you about appointments or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you, such as case management or care coordination.

Business Associates

- We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer systems, or to do our billing. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

Communicable Diseases

- To the extent authorized by law, we may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.

Communications with Family and Friends

- We may disclose information about you to persons who are involved in your care or payment for your care, such as family members, relatives, or close personal friends. Any such disclosure will be limited to information directly related to the person's involvement in your care.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Coroners, Medical Examiners, and Funeral Directors

- We may disclose health information about you to a coroner or medical examiner, for example, to assist in the identification of a decedent or determining cause of death. We may also disclose health information to funeral directors to enable them to carry out their duties.

Disaster Relief

- We may disclose health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated, we will use our professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Food and Drug Administration (FDA)

- We may disclose health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

Health Oversight

- We may disclose health information about you for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to our provision of health care, or to the health care system.

Judicial or Administrative Proceedings

- We may disclose health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.

Law Enforcement

- We may disclose health information about you to a law enforcement official for certain law enforcement purposes. For example, we may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness, or make a report concerning a crime or suspected criminal conduct.

Minors

- If you are an unemancipated minor under California law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

Notification

- We may notify a family member, your personal representative, or other person responsible for your care, of your location, general condition, or death.
- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Organ and Tissue Donation

- We may disclose health information about you to organ procurement organizations or similar entities to facilitate organ, eye, or tissue donation and transplantation.

Parents

- If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.
- In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Personal Representative

- If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

Public Health Activities

- As required or permitted by law, we may disclose health information about you to a public health authority, for example, to report disease, injury, or vital events such as death.

Public Safety

- Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.

Required By Law

- We may disclose health information about you as required by federal, state, or other applicable law.

Specialized Government Functions

- We may disclose health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veterans' benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.

Workers' Compensation

- We may disclose health information about you for purposes related to workers' compensation, as required and authorized by law.

Any Other Use or Disclosure -- Authorization Required

- Before using or disclosing your personal health information for any other purpose not identified above, we will obtain your written authorization. Unless action has already been taken in reliance on the authorization, you have a right to revoke such authorization by submitting your request in writing to us (see section II above for contact information).

V. Your Health Information Rights

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
- Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.
- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
- Request that we amend the health information about you that is maintained in our files and the files of our business associates (if applicable). Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.
- Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge, however if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, "from May 1, 2003 to June 1, 2003"). We will be unable to provide you an accounting for any disclosures made before April 14, 2003, or for a period of longer than six years.
- Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section II above for information). If you have questions about your rights, please speak with our contact person, available in person or by phone, during normal office hours.

VI. To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person (see section II above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-(800) 368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint.

VII. Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice and make copies available to our patients and others.

Effective Date: August 1st, 2008

Thank you for entrusting me as your provider.

Valley Family Psychiatry
Niraja T. Patel, D.O.
Child and Adult Psychiatry

"Your Psychiatric Care"

9821 E. Bell Road, Suite #100
Scottsdale, AZ
Office: (480) 939-3339
Fax: (480) 718-9519

Welcome

This letter is designed to introduce you to the policies and methods of my medical practice. Communication is necessary for the sound doctor-patient relationship, so please let me know if you have any questions about this information.

Psychiatric Practice

I have specialized in adult psychiatry and subspecialized in child and adolescent psychiatry. Children, adolescents, adults, and families are in my practice. I diagnose and treat disorders of feeling, thinking, and behaving. Treatments include medication evaluation and/or psychotherapy (individual and family) on an outpatient basis.

Appointments/Office Hours

Appointments are made directly with me. No walk-in appointments are accepted. Please call in advance so I can reserve time for you. Appointments begin promptly and in consideration for the next patient, I will need to end your appointment at the specified time. If you are late for your appointment, you will still be charged the full rate of your scheduled appointment.
If an appointment is missed or cancelled less than 24 hours in advance, you will be charged at the full rate of your scheduled appointment

Payments

Fees are based upon the length of appointment time. Please make full payment at the time of each appointment. Extended phone calls over 5 minutes may be billed. Accounts not paid on a timely basis will be sent to a collection agency. There will be a $25.00 service fee for all returned checks.

Emergencies

Not for medication refills or appointment changes
If I am not in my office, you can reach me by my voicemail (480-871-6363) There is always another psychiatrist on call when I am out of town. If you are not able to reach me immediately in an emergency, please go to your nearest emergency room.

Tests and Prescriptions

Special tests are sometimes necessary to help diagnose psychological or learning disorders and/or help determine whether there is a physical cause for the emotional problems. The use of certain medications will require laboratory monitoring. I will discuss the use of all tests with you and your child prior to ordering medication, and will provide you with the results as soon as I receive them.

Medication may be prescribed as part of the treatment and I will explain its expected emotional and physical effects. Please call me if you experience any unexpected changes. It is imperative that you keep appointments to monitor progress and the possibility of side effects.

Confidentiality

The medical records of patients are confidential. Information contained in them will not be released unless permitted by law or your written consent. The law sets limits on confidentiality if the patient is a danger to self and/or others and if child/elder abuse/neglect is suspected. When treating a child/adolescent, I keep parents informed of the general progress of treatment. Information given to me by the child/adolescent is kept confidential. In cases where I believe certain information must be told to the parents, I will discuss it first with the child/adolescent.