Dr. Marc Schwartz, DO

The ARIZONA SCHWARTZ GROUP
Child, Adolescent, Adult Psychiatry

Fax 866-831-1158
Tel 480-899-4077
www.azSchwartzGroup.com

Child & Adolescent Intake Form

Referred By

Name	Phone
Address	☐ Pediatrician ☐ Primary Care Physician ☐ Psychologist ☐ Counselor ☐ Friend

Patient Information

Name	Gender ☐ Male ☐ Female	Date
Address	DOB	Age
	Email	
Mobile Phone	Home Phone	

Parental or Guardian Information

Mother	Age	Father	Age
Address		Address *(if different)*	
Occupation		Occupation	
Home Phone		Home Phone	
Mobile Phone		Mobile Phone	
Email		Email	

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Social Services Agency *(if applicable)*

Is agency the Legal Guardian? ☐ *Yes* ☐ *No*

Agency Name	Contact Person
Address	Phone
	Fax

School Information *(Complete only those fields that apply)*

Name		Grade	Phone
Address		IEP: ☐ Yes ☐ No *If yes, what is IEP for:*	
Principal	Phone	Teacher	Phone
Psychologist	Phone	If Special Education, what services? ☐ Resource Room ☐ Occupational Therapy ☐ Speech-Language ☐ Physical Therapy/Ed ☐ 1 to 1 Para ☐ Other	
Guidance Counselor	Phone		

Family members residing in the home

Name	DOB	Age	Gender	Relationship
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐ ☐	
			☐ ☐	

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Mental Health History

Hospitalizations ☐ *Yes* ☐ *No* If yes, how many? _____

Hospitals	Date	Reason

Psychotherapy – *(Current and Past)*

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Prescriber – Physician or Nurse Practitioner *(Current and Past)*

Clinician Name: _____Dates _____ to _____

Type: Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: Fax: Email:

Clinician Name: _____Dates _____ to _____

Type: Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: Fax: Email:

Clinician Name: _____Dates _____ to _____

Type: Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: Fax: Email:

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Psychiatric Medication History

Current Psychiatric Medications and/or Supplements ☐ *Yes* ☐ *No*

Medication/Supplement	Dose	Start Date	Side Effects

Previous Psychiatric Medications and/or Supplements ☐ *Yes* ☐ *None*

Medication/Supplement	Dose	Start Date	Stop Date	Reason for stopping

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Medical History

Primary Care Doctor or Pediatrician

Name	Phone
Address	Fax

Medical or Surgical History

Medical Diagnosis or Surgery	Date Diagnosed	Treating Physician Name	Phone

Current Medications *(other than psychiatric)*

Medication	Dose	Start Date	Treating Diagnosis	Side Effects

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Allergies ☐ *None* ☐ *Yes (see below)*

Medication Allergies

Name	Reaction

Food Allergies

Name	Reaction

Food Sensitivities

Name	Reaction or Symptom

Other Allergies

Name	Reaction

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Family History of Mental Health Disorders *(Leave blank if not applicable)*

Diagnosis	Relationship to Patient	Treated or Untreated
Alcohol Abuse/Dependence		
Anger Problems		
Anxiety *(Generalized or Panic Disorder)*		
Attention Deficit Hyperactivity		
Autism		
Behavior/Conduct Problems		
Bipolar Disorder		
Depression		
Eating Disorders		
Gambling Problems		
Learning Disorders		
Intellectual Disability		
Obsessive Compulsive (OCD)		
Schizophrenia		
Suicide - Attempts		
Suicide - Completed		
Substance Abuse		
Tic Disorder		
Other		

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Developmental History

Birth History

Duration of Pregnancy (weeks) _____

Complications during Pregnancy ☐ No ☐ Yes, explain _____

Labor

Duration _____

Complications ☐ No ☐ Yes, explain _____

Delivery ☐ Vaginal ☐ C-Section

Complications, if any _____

Newborn Period ☐ Normal

☐ Problems or treatment needed (Oxygen, Incubator, Infection, Jaundice requiring treatment, Breathing difficulties, or other) _____

_____

Developmental Milestones

First Year - Temperament

☐ Yes ☐ No Easy Baby

☐ Yes ☐ No Slow to warm up _____

☐ Yes ☐ No Difficult baby _____

☐ Yes ☐ No Colic _____

Eating habits ☐ Normal ☐ Abnormal _____

Sleep habits ☐ Normal ☐ Abnormal _____

Milestones

Age at first words _____

Age speaking sentences _____

Age toilet trained:

Bladder _____

Bowel _____

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Social History

Peer Relationships ☐ Satisfactory ☐ Unsatisfactory *Explain*:

Reason for seeking treatment *(In Brief)*

Thank you for your time in completing this form. All of the information will help Dr. Schwartz provide a thorough and comprehensive assessment. Any additional information not covered in this form that you think is helpful and important information, please feel free to detail it below.

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Additional Information *(If applicable)*

The ARIZONA SCHWARTZ GROUP

Consent to Release Information

Date: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I, _____, hereby authorize **Dr. Marc Schwartz, DO** (The Arizona Schwartz Group, PC) to: ☐ (send) ☐ (receive) the following information marked below ☐ (to) ☐ (from)

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

- ☐ Academic testing results
- ☐ Behavior programs
- ☐ Progress reports
- ☐ Intelligence testing results
- ☐ Medical records/reports
- ☐ Personality profiles
- ☐ Psychological reports
- ☐ Phone contact
- ☐ Other, specify_____
- ☐ Psychological testing results
- ☐ Service plans
- ☐ Summary reports
- ☐ Vocational testing results
- ☐ Entire record, except progress notes
- ☐ Behavioral and Emotional Scales
- ☐ Laboratory Tests
- ☐ All information, all charts, all communication

The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or program
- ☐ Continuing appropriate treatment or program
- ☐ Determining eligibility for benefits or program
- ☐ Case review
- ☐ Updating files
- ☐ Other (specify) _____

10165 N 92nd St, Suite 101, Scottsdale AZ 85258
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OVER →

The ARIZONA SCHWARTZ GROUP

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered
by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ☐ Self ☐ Parent/legal guardian ☐ Personal representative
☐ Other (describe)_____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: ____/____/_____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: ____/____/_____

Witness (if client is unable to sign)

Signature: _____ Date: ____/____/_____

Provider Signature _____ Date: ____/____/_____

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The ARIZONA SCHWARTZ GROUP

Office Policies

- *Thank you for your visit to our office.* All payments are due at the time of service. You will be provided with an invoice, which can be sent to your insurance company for possible reimbursement (*with your HCFA form provided by your insurance company*). The Arizona Schwartz Group, PC does not participate with any health insurance plans or policies.
- As with all medical practices, we have a **24 hour cancellation policy** for all appointments. We hope that you respect that each appointment is a designated time for your care. **If you are unable to make your appointment, we respectfully request at least 24 hours' notice, otherwise you will be charged a full session fee.** Proper cancellation notice allows our office to schedule as many patients as possible, which in turn reduces any waiting list we may have, and thus allows us to schedule patients who wish to come in as soon as possible. Thank you for your cooperation.
- Office staff will attempt to confirm/remind you by phone all appointments two business days before your scheduled time. However, circumstances may occur when we are unable to make this call or even reach you due to various possible issues (i.e., wrong/changed phone number, voicemail is full, no answer, etc.). As a result, you will be responsible for keeping track of your own appointments in order to avoid the full appointment fee for those missed appointments which are cancelled/rescheduled less than 24 hours.
- Our office keeps a very strict schedule of appointments that run on the hour and half hour. Due to the scheduling needs of other patients throughout the day, we are unable to run over your allotted time should you present late for your scheduled appointment. Any time spent in session when late will still accrue the full session fee.
- All prescription refill requests should be faxed directly from your pharmacy. Calls to the office should only be made for medications which are controlled substances that require a written prescription. Please allow 24 hours to review refill requests and complete them when indicated. Keep in mind, **Dr. Schwartz may not be able to refill medications if you have not followed up for an appointment as expected.** A combination of medical, legal, and ethical laws and statutes, prohibit him from doing so. All significant medication changes must be discussed during a scheduled office appointment and not via phone contact or email. Note, prescription refills cannot be completed over the weekend, thus it is important to allow sufficient time so you do not run out of your medications inadvertently.
- There is no charge for quick, routine letters needed throughout your treatment, However, a more complex letter such as those stating diagnoses, treatment recommendations, school IEP letters, etc., will be billed at an hourly rate of $300 in 15 minute increments. The same rate applies to any forms that need to be completed as well. Neither provider will provide any court evaluations, instead focusing their practice solely on the clinical treatment of patients. For any court related matters, The Arizona Schwartz Group can refer you to a forensic psychologist or psychiatrist. Please be mindful that completing forms for insurance claims, disability claims, FMLA claims, etc., can be quite time consuming, and this will also be billed at the hourly rate of $300 in 15 minute increments.
- Copies of medical records for self or medical claims, will be billed at a flat fee of $25.
- **Payment is due at time of service. We accept cash and all credit cards, except CARE CREDIT.**
- The Initial Consultation is an evaluation regarding diagnosis and treatment recommendations. The Arizona Schwartz Group reserves the right to determine if treatment should continue with here or be referred out to clinical specialists who would better serve the diagnosis at hand. The Arizona Schwartz Group also reserves the right to terminate treatment of any patient who does not meet compliance with office policies, willfully disregards treatment recommendations and protocols, or is disrespectful or threatening towards office staff.
- While we take measures to secure email, all email use will be solely at the risk of each patient.

The ARIZONA SCHWARTZ GROUP

Acceptance of Policies and Terms:

I have read, understand, and accept the provisions of this agreement. I have no questions regarding the office policies set forth and understand that should any questions arise, I can contact the office. I also understand that if I violate any provisions of this agreement, my treatment may be terminated. I understand that this agreement is binding in the State of Arizona and is set forth for my protection, as well as for the protection of The Arizona Schwartz Group. The original agreement will become part of my confidential medical records.

_____ _____

Signature of Patient, Parent or Legal Guardian Date (mm/dd/yr)

_____ _____

PRINTED NAME

The Arizona Schwartz Group, PC

Notice of Privacy Practices for Protected Health Information

Effective date of this notice is July 2nd, 2007

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.

In compliance with the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), The Arizona Schwartz Group, PC has established privacy policies and procedures relating to the protected health information of our patients. Protected health information is information related to your past, present, or future physical or mental health or condition, or payment for such, in which you personally could be identified. HIPPA requires that providers must maintain the privacy of protected health information, provide a notice of their legal duties and privacy practices, and abide by the terms of the privacy notice currently in effect.

If you have any questions about our privacy practices or any of the information contained in this Notice of Privacy Practices for Protected Health Information ("Notice"), or wish to register any complaints related to our privacy practices, you should contact:

Dr. Marc Schwartz, D.O. (Arizona Schwartz Group, PC)
10165 N 92nd St, Suite 101
Scottsdale, AZ 85258
(480) 899-4077

We will supply a written copy of this Notice to any person requesting it, whether or not they are a current patient. All patients will be given a copy of this Notice at the time of the first service provided to them following the effective date listed above. This Notice will be posted prominently and copies will be made available in our office.

We reserve the right to make changes to our Notice and have any new provisions become effective for all protected health information we maintain. If we make any material changes to the uses or disclosures of protected health information, the individual's rights, our legal duties, or other privacy practices stated in this Notice, this Notice will be revised. The revised Notice will be posted prominently in our office, and we will make the revised Notice available to anyone who request a copy.

YOUR RIGHTS AS A PATIENT

With respect to your protected health information, you (or your personal representative, with legal authorization) have certain rights:

1. TO OBTAIN A PAPER COPY OF THIS NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION UPON REQUEST.
2. TO REVOKE YOUR CONSENTS OR AUTHORIZATIONS.
3. TO INSPECT AND OBTAIN A COPY OF THE HEALTH INFORMATION THAT IS USED TO MAKE INDIVIDUAL HEALTHCARE DECISIONS ABOUT YOU (SO CALLED "DESIGNATED RECORD SETS").
4. TO APPEAL DECISIONS WE MAKE REGARDING DENIAL OF ACCESS TO YOUR RECORDS.
5. TO REQUEST AMENDMENTS TO YOUR HEALTH RECORD.
6. TO DISPUTE DECISIONS WE MAKE REGARDING DENIAL OF AMENDMENTS TO YOUR RECORDS.
7. TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES.
8. TO REQUEST THAT CONFIDENTIAL COMMUNICATIONS TAKE PLACE BY ALTERNATIVE MEANS OR TO ALTERNATIVE LOCATIONS.
9. TO OBTAIN AN ACCOUNTING OF DISCLOSURE.
10. TO LODGE A COMPLAINT WITH US OR WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES IF YOU BELIEVE THERE HAS BEEN A HIPPA PRIVACY VIOLATION, WITHOUT FEAR OF RETALIATION, COERCION, OR INTIMIDATION.

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as 'The Health Insurance Portability and Accountability Act of 1996' ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____ (printed name of patient or legal guardian), acknowledge that The Arizona Schwartz Group, PC have provided a written copy of its Notice of Privacy Practices for Protected Health Information for:

_____ _____

Signature of Patient, Parent or Legal Guardian — Date Printed (mm/dd/yyyy)

_____ _____

Printed Name — Relationship

THE ARIZONA SCHWARTZ GROUP, PC

APPOINTMENT REMINDER PREFERENCES/UPDATE

10165 N 92nd St, Suite 101
Scottsdale AZ 85258
Tel: 480.899.4077
www.azSchwartzGroup.com

Patient Name		Date of Birth	

Contact Information (If under 18 Parent/Guardian information) Please check box if okay to leave a detailed message ↓

Name		Phone #(H)	☐
Complete Address		(Cell)	☐
	Email		

Emergency Contact Information

Name		Phone #(s)	
Relationship			

Pharmacy Information (only for patients of Marc Schwartz, DO)

Pharmacy		Address
Phone #		

Appointment Reminders

The Arizona Schwartz Group can now send appointment reminders via text, email and automated phone message. If you wish to receive these reminders we require your consent**. Please initial** to indicate your understanding of the following:

☐	Reminder messages are generated using a secure service. I understand that they are transmitted over a public network onto a personal telephone and/or computer and as such may not be secure. The practice will not transmit any information which would enable an individual patient to be identified.
☐	I acknowledge that appointment reminders are a courtesy and that I am responsible for keeping track of my appointments. Circumstances may occur where the Arizona Schwartz Group is unable to send reminders, or we are unable to reach you, and the responsibility of attending appointments or cancelling them still rests with me. **I understand that if I cancel or reschedule an appointment with less than 24 business hours' notice, I will be charged for the full amount of the appointment.**
☐	Messaging options can be cancelled at any time. Text messaging rates may apply. I agree to advise the practice of any changes to my phone numbers or email address.

You can elect to receive a text message *and* email *or* automated phone message reminders. If you do not elect a text message, you will receive only one appointment reminder (either an automated message OR an email). By checking the below box(es), I hereby authorize members of the Arizona Schwartz Group to leave appointment reminders at the provided number(s) and/or email address:

☐ Mobile # (for text msgs)		**Or**: (please choose **one**)	☐ Phone # (for automated msgs)	
☐ Email			☐ Email	

_____ _____

Patient or Parent/Guardian Signature Date

THE ARIZONA SCHWARTZ GROUP, PC

THE ARIZONA SCHWARTZ GROUP, PC

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Ph 480-899-4077
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CREDIT CARD ON FILE AGREEMENT

As an authorized signer on the credit card listed below, I give Dr. Marc Schwartz, DO and The Arizona Schwartz Group permission to utilize the credit card for all charges related to and including services rendered by Dr. Marc Schwartz, DO and the Arizona Schwartz Group

Credit Card Number: _____

Expiration Date: _____

Security Code or CID #: _____

Billing Zip Code: _____

Name on Card: _____

Name of Patient: _____

Phone Number: _____

_____ _____

Signature Date

For Secure Video Sessions, please provide your preferred email address we can send the link to to Doxy.me, which is the secure server we use

Email:

For Phone Sessions, please provide your preferred phone number for Dr. Schwartz to call for the appointment session

Phone: