PATIENT – CLIENT INFORMATION

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Mailing Address_____ City_____ State _____ Zip_____
(If different)

Phone: Primary _____ Secondary _____
(Best place to reach you)

Can we leave messages at either number? Yes or NO

If not, where would you like for us to leave a message? _____

Person responsible for your account _____ relationship_____

Relationship status: Single Married Partnered

Name of Spouse/Partner (parents/guardian for minor)_____

Children & Ages (siblings for minor) _____

Name of primary physician _____ Phone_____

In case of emergency notify _____ Relationship_____Phone_____

Referred by_____

Please explain why you are seeking help at this time:

_____

_____

Please explain how your problems are affecting your work and relationships, plus your general functioning:

_____

_____

_____

_____

On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now _____

Please check any health problems you have or have had:

_____lung	_____high blood pressure	_____arthritis
_____liver	_____diabetes	_____other pain
_____kidney	_____seizures	_____cancer
_____stomach/intestinal	_____head injury	

Page 2 – Patient/Client Information

Name_____ Date of Birth _____

Medicines you are allergic to:

_____

_____

Medicines you now take:

_____

_____

_____

_____

How much and what kind of exercise you get:

_____

_____

Height _____ Weight _____

SUBSTANCE USE	Average amount Past 2 months	Most ever used
Coffee	_____	_____
Cigarettes	_____	_____
Alcohol	_____	_____
Recreational Drugs	_____	_____

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

___Physical health
___Chronic Pain
___ Low mood
___ Mood swings
___ Energy/motivation level
___ Memory
___ Concentration
___ Sleep
___ Sexual functioning
___Suicidal thoughts
___ Spirituality/religion
___ Marriage/relationship
___ Family conflicts

___ In-law problems
___ Job or school performance
___Friendships
___Financial problems
___ Obsessions (unwanted thoughts)
___ Nightmares
___ Thoughts of hurting someone
___ Compulsions (unwanted actions)
___ Flashbacks
___ Paranoid thoughts
___ Domestic violence (verbal)
___ Domestic violence (physical)
___ Drinking alcohol

___Using drugs
___Panic Attacks
___Phobias
___ Anxiety symptoms
___*sweating*
___ *short of breath*
___ *stomach upset*
___*dizziness*
___ *choking*
___ *racing heart*
___ *weakness*
___*dry mouth*
___*feeling trapped*
___ *panic*

For the following, please circle YES or NO and give details:

Have you had counseling or psychotherapy in the past? YES - NO _____
Have you ever taken medication for your emotional or mental health? YES – NO _____
Have you ever been hospitalized for psychiatric problems? YES – NO _____
Have you ever been arrested? YES – NO _____
Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES – NO

_____
Have you ever had any experiences that you would consider traumatic or abusive? YES - NO

_____
Have you ever tried to kill yourself or hurt yourself in any way? YES – NO _____
Is there any danger these days that you might hurt yourself or someone else? YES – NO _____

Page 3 – Patient Client Information

Name_____Date of Birth_____

Please describe your education:

_____

Please describe the family you grew up in including your parents and names and ages of your siblings:

_____
_____
_____
_____
_____

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:

_____
_____
_____
_____
_____

Please describe your support system (family you are close to, friends you talk with, etc.):

_____
_____

What is your current job and how do you like it?

_____
_____
_____

Please describe your religious affiliation and practice, if any:

_____
_____
_____

Kathé Reitman, PMHNP, BC
2020 Financial Agreement- page 1 of 2

I understand that I will pay in full for services at the time of my appointment unless I have insurance coverage that requires another arrangement, or I make a different agreement with my provider.

My initials indicate that I have read and agree with each item below

Professional Fees:

_____ Any co-payment or co-insurance is due in full at the time of service
_____ Special financial arrangements must be discussed with my provider
_____ Parents/Guardians are financially responsible for payments for services provided to minor Or other dependents
_____ A $25 processing fee will apply for any returned check
_____ A fee schedule of usual and customary chargers in available upon request
_____ Fees may include charges for other professional services such as:
1) Reports 2) Telephone conversations between appointments 3) Consulting with Professionals 4) Preparation of records / treatment summaries 5) testing 6) legal proceedings, including preparation time and transportation 7) Prior authorizations on medications or appeals to insurance companies

Payment for Services

_____ It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section of my insurance coverage booklet that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered or are denies by my insurance plan

_____I will provide full and accurate insurance information in advance of my appointment, or will pay for the appointment on a self pay basis. I will present my insurance card at the time of my appointment. I will provide updated insurance information promptly in the case of any changes.

_____I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy. I remain the responsible party.

_____ I understand that if after 90 days my insurance company has not responded, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

_____I understand that if my account is referred to a collection specialist due to non-payment, I will pay any applicable collection fees.

Policy for Missed Appointments and Cancellations

_____I agree that I must give proper notification to avoid late cancellation or no show fees. I agree to call at least **24 hours in advance to cancel or change my appointment.** For Monday appointments I will call the previous Friday to avoid a late cancellation /no show fee. **I understand that any missed or appointment cancelled in less than 24 hours will be automatically billed to my credit card #**_____

Patient Rights

_____ I understand that as a patient, I have the right to:

1) Request Restrictions
2) Receive confidential communications by alternative means and at alternative locations
3) Inspect and Copy
4) Amend
5) Receive accounting
6) Receive a paper copy of my records

Rates for Patients who do not use Insurance ("Self Pay")

_____Initial or re-evaluation	(45-60 minutes)	$265.00*
_____Re-evaluation (1 yr)	(30-45 minutes)	$230.00*
_____Extended appointments	(30-45 minutes)	$230.00*
_____Extended medication check	(15-30 minutes)	$160.00*
_____ Brief medication check	(5-15 minutes)	$115.00*

**When the bill is paid in full on the day of the appointment, patient cost is reduced $15.00 due to our savings in administrative time and expense.*

If a patient has not been seen in a full year, then schedule a 45 minute "re-evaluation;" otherwise, others can schedule an appt as usual . . . 15/30 minute or whatever is required.

If there is a balance due on your account, the payment will go towards the old balance first. In order to receive a $15 discount off the visit, the previous balance as well as that day's appointment must be paid in full.

I have read, understand, and accept the terms of these financial policies:

_____

Patient Signature date

_____

Responsible Party Signature date

Revised 11/18/2019

KATHE REITMAN, M.S., A.P.R.N., B.C.

HEALTHCARE PROVIDER / PSYCHOTHERAPIST—PATIENT SERVICES AGREEMENT

Name _____ **Date of Birth** _____

Welcome, I am pleased you have chosen me as your healthcare provider. Please read the following document carefully as it contains important information about my professional services and practice policies.

Medication Services

Your treatment may include taking medication. There are wide varieties of medications available for sleep or sleepiness problems as well as for mental health problems such as depression or other mood disorders like bipolar disorder, anxiety, posttraumatic stress disorder, psychotic disorders and others. Prescribing of medication must take into account your personal medical history, other medications that you take, allergies to medicines or other products and your treatment goals. When I recommend a medication prescription for you, I will inform you of significant benefits and risks, answer any of your questions to the best of my ability and advise you about appropriate regular monitoring of your use of medication, including any necessary periodic laboratory tests.

_____ **Initial Here**

Psychotherapy Services

Your treatment may include psychotherapy, which is not easily described in general statements. It varies depending on the personalities and preferences of both the psychotherapist and the patient and the particular problems you are experiencing. There are many different methods that I may use to deal with problems that you want to address. Psychotherapy can have benefits and risks. There are no guarantees of what you will experience. Our first session will involve an evaluation of your needs. I will offer you some first impressions of what our work together will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If your doubt persists, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

_____ **Initial Here**

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. When I am temporarily unavailable, my telephone is answered by my office staff or answering service. I will make every effort to return your call promptly during my business hours. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room or dial 911. If I will be unavailable for an extended time, another healthcare provider will be available to take emergency calls.

_____ **Initial Here**

Legal Limits on Confidentiality Protections

The law protects the privacy of all communications between a patient and a healthcare provider. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Information Portability and Accountability Act (HIPAA). There are other situations that require only that you provide written, advance consent. However, there are some situations in which I am permitted or ***required*** to disclose information without either your consent or Authorization. These situations are primarily related to danger to yourself or to others and child or elder abuse or neglect. If such situations arise, I will make every effort to discuss them with you before taking any action and I will limit my disclosure to what is necessary. For details on the limits of your confidentiality required by law, please refer to my office form entitled, "Notice of Healthcare Provider's Policies and Practices to Protect the Privacy of Your Health Information," especially Section II ("Uses and Disclosures Requiring Authorization") and Section III ("Uses and Disclosures with Neither Consent nor Authorization"). Your signature on this Agreement provides consent for those activities. While this written summary of exceptions fo confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have

now or in the future. The laws governing confidentiality can be quite complex and I do not give legal advice. In situations where specific advice is required, formal legal advice may be needed.

_____ **Initial Here**

Minors & Parents

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, it is sometimes my policy to request an agreement from parents that they consent to give up or suspend their access to their child's records. If they agree, during treatment I will provide them only with general information about the progress of the child's treatment, unless the child agrees otherwise. Before giving parents any information that the child expects to be confidential, I will discuss the matter with the child, if possible, and do my best to handle any objections. Important exceptions to this confidentiality procedure involve any issue or potential issues regarding matters of the child's safety. I will ensure that parents are rapidly informed about any safety concerns that come to my attention. This may be done by promptly scheduling a joint session to be attended by both child and parents so that the child can inform the parents of the safety issue himself or herself in the context of the support offered in a therapy session. Alternatively, if the child is not able to agree to a joint meeting for any reason or if the safety concern is urgent, I may telephone one or both parents to quickly discuss the relevant safety concern. Parents should feel free to clarify this policy or request modifications to it at any time they become aware of a safety concern for their child.

_____ **Initial Here**

Professional Records

You should be aware that, pursuant to the Health Information Portability and Accountability Act (HIPAA), I keep Protected Health Information (PHI) about you in two sets of professional records. Please refer to the "Notice of Healthcare Provider's Policies and Practices to Protect the Privacy of Your Health Information," for more information regarding the above.

_____ **Initial Here**

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protected Health Information (PHI). These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the locations to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

_____ **Initial Here**

CONSENT FOR TREATMENT AND CONSULTATION

I authorize and request that Kathe Reitman, M.S., A.P.R.N., B.C., carry out behavioral health treatments, and/or diagnostic procedures that now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVIES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPPA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Patient or (Authorized Parent/Guardian Name) **Printed** Date

_____ _____

Patient or (Authorized Parent/Guardian Name) **Signature** Date

FILL OUT THIS PAGE IF YOU HAVE SLEEP PROBLEMS

Name_____ Date of Birth_____

What is the main problem with your sleep? _____
Are you a shift worker? **YES** or **NO** If so, what hours do you work? _____
On average, how many hours of sleep do you get in 24 hours? _____
All at once or with naps? _____ Is this enough? **YES** **NO** Or too much? **YES** **NO**

INSOMNIA - POOR SLEEP QUALITY

Do you have problems getting to sleep or staying asleep? **YES** **NO**
If so, is your main problem getting to sleep, or waking up too much, or both? _____
Do you tend to sleep at the wrong time; that is, are you an extreme night owl or morning lark? **YES** **NO**
If so, what is your best window of time for sleeping? _____
Do you legs or arms itch, burn, tingle or just feel "fidgety" when you are trying to sleep? **YES** **NO**

EXCESSIVE SLEEP OR SLEEPINESS

Are you often too sleepy when you need to be awake? **YES** **NO**

On your usual schedule in recent weeks or months, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to answer according to how you think they might affect you. Choose the most appropriate number for each situation:
0 = would never doze **1 = slight chance of dozing** **2 = moderate chance** **3 = high chance of dozing**

Sitting & reading	0 1 2 3
Watching TV	0 1 2 3
Sitting in a public place, like a waiting room	0 1 2 3
Riding in a car for 1 hour	0 1 2 3
Lying down to rest	0 1 2 3
Sitting & talking	0 1 2 3
Sitting after lunch without alcohol	0 1 2 3
Driving a care while stopped in traffic	0 1 2 3
Total Score	_____

The Epworth Sleepiness Scale
(John, M.W. (1993) Chest 103:30-36)

If your score is 10 or higher, a sleep disorders consultation is recommended.
Other situations in which you fall asleep when you don't mean to? _____
Do you snore? **YES** **NO** Loudly enough to disturb others? **YES** **NO** Stop Breathing? **YES** **NO**

SLEEP BEHAVIORS and OTHER PROBLEMS

Do your legs or arms twitch or jerk during sleep? **YES** **NO** Whole body? **YES** **NO**
If either, do these twitches or jerks seem to interfere with your sleep? **YES** **NO**
Do you sleepwalk or act out dreams: **YES** **NO**
Do you fall out of bed or have unusual movements during sleep? **YES** **NO**
Have you ever injured yourself or someone else while asleep? **YES** **NO**
Do you have nightmares? **YES** **NO**

Kathe Reitman, PMHNP, BC
6619 N Scottsdale Road; Scottsdale, Arizona 85253

Notice of Healthcare Provider's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*" – *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – we are required to report PHI to the appropriate authorities when we have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.

- *Adult and Domestic Abuse* – If we have the responsibility for the care of an incapacitated or vulnerable adult, we are required to disclose PHI when we have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.

- *Health Oversight Activities* – If the Arizona Board of Psychologist Examiners is conducting an investigation, then we are required to disclose PHI upon receipt of an official request from the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to us an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and we believe you have the intent and ability to carry out such a threat, we have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If we believe there is an imminent risk that you will inflict serious harm on yourself, we may disclose information in order to protect you.

- *Worker's Compensation* – we may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Healthcare Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Healthcare Provider Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will mail the revised notice to the most recent patient billing address provided.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, please share your concerns with Kathe Reitman.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on November 10, 2019

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by mail to the most recent patient billing address.

Due to prescribing changes starting January 1, 2020, all pharmacy information needs to be completely filled in and updated at every visit before your appointment time starts. Not filling out all of the information may delay your appointment time.

Pharmacy Information

Today's Date: _____

Patient Name: _____ DOB _____

Patient Full Address: _____

City: _____ State: _____ Zip: _____

Patient's Phone # _____

Full Pharmacy Name: _____
(EXAMPLE: CVS Pharmacy, or COSTCO, or WALGREEN'S, etc.)

Full Pharmacy Address: _____
(EXAMPLE: 12345 N. SCOTTSDALE RD, SCOTTSDALE, AZ 85250)

*** ***DO NOT USE*** ***APPROXIMATE ADDRESS SUCH AS: HAYDEN AND SCOTTSDALE RD*** ***

Pharmacy Phone # _____ FAX _____

OFFICE NOTES: