Date:_____

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____

Preferred name/Nickname:_____

Mailing Address:_____

City: _____ State: _____ Zip Code: _____
Please let staff know if you have a billing address that is different than your mailing address

Email Address: _____

Cell Phone: _____ Home Phone: _____

Marital Status: Married_____ Single_____ Divorced_____Widowed_____

Individuals that will be responsible for payments to our office on behalf of the patient:

Name: _____ Phone Number: _____
Relation to Patient: _____
SIGNATURE: _____

Medications you are allergic to:
_____

EMPLOYER INFORMATION

Employer Name: _____ Job Title: _____
Work Phone: _____
Current level of satisfaction with job: _____

INSURANCE INFORMATION:
IF YOU HAVE MORE THAN 1 INSURANCE PLEASE JUST WRITE THE INFORMATION ON THE BACK OF THIS SHEET

INSURANCE NAME: _____MEMBERNAME:_____

MEMBER ID #: _____ EFFECT DATE: _____

BIN #:_____ PCN: _____GROUP #:_____

PERSONAL INFORMATION

Reason you are seeking help at this time:

_____

How are the difficulties affecting your work, relationships, and general functioning?

_____

Rate your level of difficulty with the following problems:
0=None 1=Mild 2=Moderate 3=Severe

__ Physical Health __ Anxiety __ Mood Swings ___ Nightmares
___ Flashbacks ___ Relationships ___ Spirituality __ Panic
___ Drugs ___ Obsessions ___ In-Laws ___ Chronic Pain
__ Job/School ___ Low Moods ___ Finances ___ Phobias
___ Memory __ Concentration ___ Sexual Functioning
___ Verbal Abuse ___ Physical Abuse ___ Family Conflicts
__ Sexual Abuse ___ Alcohol __ Sleep
___ Energy/Motivation __ Thoughts of hurting self/others
___ Paranoid thoughts

PSYCHIATRIC HISTORY

Please list any therapists you have seen for treatment and any psychiatric hospitalizations:

_____
_____

Current Psychiatric Medications:

_____

Previous Psychiatric Medications you have taken in the past and why you discontinued them:

_____
_____

Substance Use History (Coffee, Cigarettes, Alcohol, Recreational Drugs)

Substance	Current Amount Used	Most Ever Used

_____
_____

Biological family history for psychiatric illnesses/treatment (Include name, relationship, and diagnosis):

_____
_____

Any suicide in family? _____

SOCIAL HISTORY

Family of Origin: Parents/ Siblings

_____

_____

Description of family life while growing up

_____

_____

Other individuals in present household/current daily environment:

_____

_____

Children (Names/Ages)

_____

_____

Education:

_____

_____

History of arrests/traumatic experiences throughout life:

_____

_____

Religious Affiliation:_____

MEDICAL HISTORY
Any Surgeries or Illnesses:

_____

_____

Height: _____ Weight:_____ Blood Pressure: _____ Pulse: _____

Current Medications (non-psychiatric):

_____

_____

PROVIDER INFORMATION

Provider Name Specialty Address/Phone Number Permission to Contact?

_____

_____

Any other information you feel will be helpful in our work together:

_____

_____

KATHE REITMAN, PMHNP, BC
6619 N SCOTTSDALE RD STE 23 SCOTTSDALE, AZ 85250
480-296-2058 / 480-676-2809

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. We are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize KATHE REITMAN, PMHNP.BC to release my records and any information requested to the following individuals

1 NAME: _____
PHONE _____

2.NAME: _____
PHONE _____

Authorization Regarding Messages

(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

____ I Do not authorize you to leave any messages on my home or cell phone

Patient Signature: _____

Date: _____

KATHE REITMAN, PMHNP, BC
6619 N SCOTTSDALE ROAD
SUITE 23
SCOTTSDALE, AZ 85250
480-296-2058 / 480-676-2809

AGREEMENT NOT TO USE MY MEDICAL INSURANCE

DATE:
PATIENT NAME:
DOB:

This is to confirm that I am voluntarily choosing not to use my managed care or medical insurance coverage for services provided by Kathe Reitman,PMHNP,BC as of the following dates:

_____

I will be paying for all services provided by Kathe Reitman,PMHNP,BC out of pocket, and will not bill my insurance for reimbursement.

_____
Patient/Guarantor Signature

Date: _____

2024 Financial Agreement
Kathe Reitman, PMHNP, BC

My initials indicate that I have read and agree with each item below. As a patient, I have the right to request restrictions, receive confidential communications by alternative means, amend, and receive copies of all financial transactions and medical records. Any requests must be written and sent to the office directly in order to be considered.

PROFESSIONAL FEES:

____ Any copayment or coinsurance is due in full at the time of service
____ Parents/Guardians are financially responsible for payments for services provided to minors or other legal dependents.
____ Any special financial arrangement requests must be discussed directly with my provider
____ A $25 processing fee will apply for any returned check
____ Fees may include charges for other professional services such as:
Reports, Telephone conversations between appointments, Consulting with other professionals, Preparation of records/treatment summaries, Testing, Legal proceedings (including preparation), Prior Authorizations on medications or appeals to insurance company determinations.

PAYMENT FOR SERVICES:

____ It is the signer's responsibility to know what services are covered by the patient's insurance plan. The patient has reviewed carefully the section of their insurance coverage that describes mental health services. The patient will call their plan directly with any questions about their insurance or coverage.
____ I will provide full and accurate insurance information in order that my insurance coverage can be verified by my provider's office. Any appointments without coverage verification will be "self-pay" rates until verification is obtained.
____ I understand that it is the signer's, not the insurance company, who is responsible for full payment of any outstanding or current fees. I understand that billing insurance directly is a courtesy my healthcare provider provides but the patient or designated authorized signer remains the responsible party.
____ I understand if after 90 days after billing the insurance they still have not responded, the patient will receive a statement which will need to be paid in full at that time. If the insurance submits a reimbursement the payor will be reimbursed as well once the payment is received.
____ I understand that if this account is referred to a collection specialist due to non-payment, I will pay any applicable collection fees.

POLICY FOR MISSED AND LATE CANCELED APPOINTMENTS:

___ I agree to give prior notification to avoid any late cancellation or no-show fees. I will call 24 hours in advance to cancel or change any scheduled appointments. I understand that any missed appointments or appointments not canceled in less than 24 hours will be automatically billed to my credit card: This credit card will be kept on file for any payments the patient is responsible for making to our office.

RATES FOR SELF PAY OR PATIENTS CHOOSING NOT TO USE INSURANCE
AND OR IF INSURANCE DOES NOT COVER VISIT PATIENT IS RESPONSIBLE FOR PAYMENT

_____ Initial Evaluation/Re-evaluation	(45-60 minutes)	$300
_____ Extended Appointments	(30-45 minutes)	$270
_____ Extended Medication Check	(15-30 minutes)	$185
_____ Brief Medication Check	(5-15 minutes)	$145

WHEN PATIENT PAYS FOR APPOINTMENT ON SAME DAY THERE IS A $15 DOLLAR DISCOUNT APPLIED AS LONG AS PATIENT HAS NO PREVIOUS BALANCE

CREDIT CARD WILL BE KEPT ON FILE FOR ANY PAYMENTS PATIENT HAS TO MAKE TO OUR OFFICE:

NAME ON CREDIT CARD:

_____

CREDIT CARD NUMBER:

_____

Exp. Date: _____ CVV: _____ Zip Code: _____

Acknowledgement

I, _____, have read, understand, and accept the terms of the above financial agreement.

_____

PATIENT SIGNATURE:

_____

DATE:

KATHE REITMAN, PMHNP, BC
6619 N SCOTTSDALE ROAD STE 23 SCOTTSDALE, AZ 85250
480-296-2058 / 480-676-2809

PATIENTS PREFERRED PHARMACY

PHARMACY NAME:_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP: _____

PHONE: _____ FAX: _____

PHARMACY NAME:_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP: _____

PHONE: _____ FAX: _____

PATIENT SIGNATURE: _____

DATE: _____

Office Policies and Procedures

In order to establish an understanding of what to expect during each appointment, please be sure to familiarize yourself with our office policies and procedures that are outlined below.

Appointments

- Patients are seen by appointment only. Appointment charges are based upon the time and complexity of appointment (see financial agreement). Emergency calls or after-hours appointments may result in additional charges. Be aware there is a possibility I may run 15-30 minutes late from scheduled appointment times.
- There is a 24 hour cancellation policy to avoid any no-show/late cancellation charges.
- Patients must pay all past-due charges in full before scheduling their next appointment.
- Payment disputes will be discussed at the scheduled appointment time. If a charge is waived, a refund will be immediately sent to the patient.

Insurance and Billing

- If you have a change to your insurance, address, phone number, or any other change to contact information, please contact Athena at 623-255-7417. If updates are not made before your scheduled appointment, self-pay rates may apply.
- I am contracted with several insurance plans and have an insurance specialist who will submit all claims directly to your insurance company after your appointment. Patients will be responsible for paying any out of pocket costs that are not covered by insurance at the time of the appointment. Contact your insurance provider with questions on coverage of behavioral health services.

Medication Refills

It is important to discuss all refill requests and changes to medications at the time of your scheduled appointment. If a refill is needed between appointments:

- Please contact your pharmacy to initiate the refill request process. Contact my office if your refill request was denied. Allow up to 72 hours for our office to respond to any refill requests.
- Refills are not handled by our on-call providers or after normal office hours.

Medication Refills - Narcotics and Stimulants

- Please be sure to inform the office if you are currently being prescribed any opiates (i.e. Fentanyl, Codeine, Tramadol, Methadone, Morphine, Hydrocodone), benzodiazepines (i.e. Klonopin, Ativan, Xanax) or psychostimulants (i.e: Adderall, Ritalin, Concerta).
- Psychostimulants, benzodiazepines, and partial benzodiazepines (Ambien, Sonata, Lunesta) will not be filled early. Psychostimulants are only refilled at appointments.
- Psychostimulants prescriptions are "void" 90 days from when it is written. After 90 days, the pharmacy will not fill the prescription.
- Patients taking benzodiazepines or stimulants will require follow-up appointments every 3 months in order to maintain the prescription.

Medical Records/Recommendation Letters

- There is a charge of $25 plus an additional $0.25 per page for copies of medical records. Records sent to providers offices are not charged.
- Professional letters are charged based on time and complexity.

HIPAA

In order to protect your private individual health information and in compliance with the Health Insurance Portability and Accountability Act, all information disclosed within sessions is confidential and will not be revealed to anyone outside of my office staff without your written consent, except for when required by law. There may be times the office is required to report to the authorities any reasonable suspicions of child or elder abuse, and/or danger of harm to self and/or to others unless protective measures are taken.

I, _____, have fully read, understand, and accept the above policies of this practice. I understand and accept all responsibilities if I fail to comply with the above.

_____

Signature Date

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**