622 N COUNTRY CLUB RD. SUITE D, TUCSON AZ 85716
Phone: (520)372-2272 ✦ Fax: (520)336-9163

Mental Health Intake Form

Personal Information

Name: _____ DOB: _____ Sex: □Male □Female

Sexual Orientation: □Straight □Gay □Bisexual □Other: _____ Gender Identity: _____

Date: _____ Marital Status: □ Never Married □Married □Widowed □Other: _____

Preferred Language: _____ Social security #: _____-_____-_____

License/ State ID # _____ State: _____

Ethnicity: _____ □Prefer not to answer Race: _____ □Prefer not to answer

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

Occupation: _____ Employer: _____

(OK TO LEAVE VOICEMAIL? CHECK □ next to type)

Phone Number: _____ Type: _____ □ YES □NO

Secondary: _____ Type: _____ □ YES □NO

Email: _____

Emergency Contact Name: _____ Phone: _____

Relationship: _____ Ok to leave a detailed message with? □Yes □No (Emergency contact is required, by assigning someone as my EC I understand that they will be contacted if any harm is suspected to myself or others, or in the event that I cannot be reached after multiple attempts) **If no □ is checked it will be assumed yes**

Pharmacy Name: _____ Cross Street's: _____

Primary Care Physician: _____ Phone: _____

Current Therapist: _____ Phone: _____

How Did you hear about us? □Google □Psychology Today □Other: _____

If referred by a different provider: Name: _____ Phone Number: _____

Complaint

What is your major complaint? _____

Start date: _____ Have you previously suffered from this complaint? _____

Previous therapist(s) seen for this complaint_____

Previous Treatment for this complaint: _____

Aggravating Factors: _____

Relieving Factors: _____

Current Symptoms (Check all that apply)

- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Loss of Interest
- ☐ Sleep Changes
- ☐ Appetite Issues
- ☐ Other: _____
- ☐ excessive energy
- ☐ Impulsivity
- ☐ Panic Attacks
- ☐ Suspiciousness
- ☐ Avoidance
- ☐ Fatigue
- ☐ Irritability
- ☐ Racing Thoughts
- ☐ Crying Spells
- ☐ Guilt
- ☐ Libido Changes
- ☐ Risky Activity

Medical History

Medication Allergies: medication and reaction (Example: Penicillin- Hives) □ No medication Allergies

_____
_____
_____

Current Medications: dosage, frequency taken (Include over-the-counter meds, herbs, and vitamins)

(Example: Tylenol 325MG Tablet- 2 tablets by mouth as needed) □ No medications

_____
_____
_____
_____
_____

Other Significant Doctors:

_____
_____
_____

Surgeries/ Year:

_____
_____
_____

Previous diagnosis/ mental health treatment: _____
_____
_____

Previously Treated by: _____

Previous Medications: _____

Dates Treated: _____

□Continue on back if necessary

Have you ever had, or do you have:

Yes	No	Epilepsy or Seizures
Yes	No	Stroke or TIA's (Circle)
Yes	No	Head injury
Yes	No	Loss of consciousness
Yes	No	Glaucoma
Yes	No	Difficulty Hearing
Yes	No	Tinnitus or chronic ear ringing
Yes	No	Frequent headache
Yes	No	Heart Attack or angina
Yes	No	Heart problems
Yes	No	Ankle swelling
Yes	No	High blood pressure
Yes	No	Bleeding or clotting disorder
Yes	No	Cancer (specify_____)
Yes	No	High Cholesterol
Yes	No	Diabetes(Type:_____)
Yes	No	Thyroid Problems
Yes	No	Changes in hair growth patterns
Yes	No	Heavy menstrual cycle
Yes	No	Night sweats
Yes	No	Difficulty Breathing
Yes	No	Are you on blood thinners?
Yes	No	Coughing up blood
Yes	No	Asthma
Yes	No	Exposure to or actual tuberculosis
Yes	No	Lung disease other than asthma
Yes	No	Allergies (other than to meds)
Yes	No	Hepatitis A, B, C Other (Circle)
Yes	No	GERD (acid reflex)
Yes	No	Stomach Trouble
Yes	No	Irritable bowel syndrome (IBS)
Yes	No	Blood in stools
Yes	No	Dark or black tarry stools
Yes	No	Constipation
Yes	No	Regular diarrhea
Yes	No	HIV positive or AIDS
Yes	No	Incontinence
Yes	No	Blood in urine
Yes	No	Kidney disease
Yes	No	Arthritis
Yes	No	Swollen glands
Yes	No	Skin rashes
Yes	No	Trouble sleeping
Yes	No	Are you on a diet?

Yes	No	Ever attempted suicide?	Yes	No	Sexual problems
Yes	No	Eating disorder	Yes	No	Low sex drive
Yes	No	Do you smoke?	Yes	No	Difficulty achieving orgasm
Yes	No	A drug problem	Yes	No	Difficulty with erections/arousal
Yes	No	An alcohol problem	Yes	No	Date of last pap smear_____
Yes	No	Abused or overused medications	Yes	No	Date of last cholesterol Check:
Yes	No	Are you sexually active?	_____		

□Yes □No Do you give permission to share the above information with the above listed doctors?

Family History

Were you adopted? _____ If so, at what age? _____

How is your relationship with your mother? _____

How is your relationship with your father? _____

Siblings and ages:

_____

Are your parents Married? _____

Did your parents' divorce? _____ If so, how old were you? _____

Did your parents remarry? _____ If so, how old were you? _____

Who raised you? _____

Family member medical conditions: _____

Family member mental conditions: _____

Treated with medication? _____ Medications: _____

Early Development

Where did you grow up? _____

How often did you move and where? _____

How old were you when you left home? _____

Have any immediate family members died? _____ Who? _____

Have any committed suicide? _____

Describe any neglect you have suffered, and by whom? _____

_____

Trauma suffered and by whom? _____
_____

Abuse suffered and by whom? _____
_____

Highest level of education: _____

Date Completed: _____ Location: _____

Have you ever served in the military? _____ if yes, where? _____

Dates of service: _____ Highest rank achieved: _____

Present Situation

Work ☐Full Time ☐Part Time ☐Student ☐Unemployed ☐Disabled ☐Retired

Are you married? _____ If yes, Date of marriage: _____

Are you divorced? _____ If yes, Date of divorce: _____

Prior Marriages? _____ If so, how many? _____

What is your sexual orientation? _____ Are you sexually active? _____

How is your relationship with your partner? _____

Do you have children? _____ Dates of birth: _____

How is your relationship with your children? _____

List anyone that lives with you: _____

Are you a member of a religion / spiritual group? _____

What is your level of involvement? _____

Have you ever been arrested? _____ When and why? _____

Have you ever tried the following? (Check all that apply)

- ☐ Alcohol
- ☐ Heroin
- ☐ Ecstasy
- ☐ Tobacco
- ☐ Methamphet-amines
- ☐ Methadone
- ☐ Marijuana
- ☐ Cocaine
- ☐ Tranquilizers
- ☐ Hallucinogen-s (LSD)
- ☐ Stimulants (Pills)
- ☐ Pain killers

If yes to any, list frequency/ dates of use: _____
_____

Have you ever been treated for Drug/ Alcohol abuse? _____ If yes, when? _____

For which substances? _____

Do you smoke cigarettes? □Never Smoked □Yes, If yes: how many per day: _____ □Box □Cigarettes
□No □ Stopped Smoking When: _____

Do you use any other type of Tobacco/ Nicotine products? □Yes □No Type: _____

Do you drink Alcohol? □ Never drank Alcohol □Yes, If yes, how many? _____□ Per Day _____ □Per Month
□No □ Stopped Drinking When: _____

Do you drink caffeinated beverages? □ Yes, If yes, how many per day _____ □ No

Have you ever abused prescribed drugs? _____ If yes, which ones? _____
_____

Exercise Frequency: _____ Exercise Type: _____

Anything else you want the physician to know?

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Signature **Date**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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A2663B 10-04-2005

Name: _____ Date: _____

Generalized Anxiety Disorder 7- item (GAD-7) Scale

Over the last 2 weeks, how often have you How often have you been bothered the following problems?	Not at All sure	Several days	Over half the days	Nearly every Day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
Add the scores for each Column	_____ +	_____ +	_____ +	_____

Total Score (add your column scores) = _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with Other People?

Not difficult at all _____
Somewhat difficult_____
Very difficult _____
Extremely difficult _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate, and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders- panic disorder (sensitivity 74%, Specificity 81%) social anxiety disorder sensitivity 72%, Specificity 80%) and post-traumatic stress disorder (sensitivity 66%, Specificity 81%)

Name: _____ Date: _____

The Rapid Mood Screener (RMS): a novel and pragmatic screen for bipolar I disorder

Table 3 of 6

Table 3. Rapid Mood Screener final 6-item set

Item	Response	
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	Yes	No
2. Did you have problems with depression before the age of 18?	Yes	No
3. Have you ever had to stop or change your antidepressant because it made you irritable or hyper?	Yes	No
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with racing thoughts in your head?	Yes	No
5. Have you ever had a period of at least 1 week during which you felt the following: unusually happy: unusually outgoing: or unusually energetic?	Yes	No
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	Yes	No

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

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Name:_____

Date:_____

Suicide Risk Screeing

In the past few weeks, have you wished you were dead?	Yes No	□ □
In the past few weeks, have you felt that you or your family would be better off dead ?	Yes No	□ □
In the pst few weeks, have you been having thoughts of killing yourelf?	Yes No	□ □
Have you Ever tried to kill yourself? If yes, How?	Yes No	□ □
If you have answered yes to any of the above, please answer the following question:		
Are you having thoughts of killing yourself right now?	Yes No	□ □

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

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

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

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NAME: _____ DATE: _____

MacLean Screening Instrument for BPD

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

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Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996(HIPPA). Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information.
- Your privacy rights.
- Our obligation s concerning the use and disclosure of your health information.

We may use and disclose your health information the following ways:

1. Treatment: Physicians and staff may use and disclose your health information to order and treat you or assist others in your treatment. additionally we may disclose your health information to others who may assist in your care, such as your spouse, children, or caregiver.
2. Payment: Our practice may use your health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for your treatment. We may also use and disclose this information to obtain payments from third parties that may be responsible for such costs, such as family members. also we may use your health information to bill you directly for your services and items.
3. Health Care Operations: We may use and disclose your health information to be able to run our practice at the highest clinical standards and effectively as possible. This could be used to evaluate the performance of our Physicians and staff to determine if our treatment plans are effective or determine if there are other services we could be offering. We may also compare our data with other practices, review it with medical students, medical faculty, technicians, and others for teaching and learning purposes. We strive to remove information that identifies you from this medical information.
4. Disclosures required by law. Our practice will use and disclose your health information when we are required to do so by federal, state, or local law.
5. Appointment reminders: We may want to call you by phone for appointment reminder purposes. Please advise us if you do not want us to call and leave appointment reminder, messages at any voicemail for any of the phone numbers provided, or with anyone possibly answering the phone.

Use and disclosure of your health information in certain special circumstances.

The following circumstances may require use or disclosure of your health information:

1. To the public authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If asked to do so by Law enforcement official.
4. when necessary to reduce or prevent a serious threat to your health and safety for the health and safety of another individual or the public. We will only make disclosure to person or organization to help prevent the threat.
5. If you are a member of the U.S or Foreign Military Forces (Including Veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To the correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For workers compensation or similar programs.

Your rights regarding your health information:

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however if we do agree we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our privacy officer.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our privacy officer.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy at any time. To obtain a copy of this notice, contact our privacy officer.
6. Right to file a complaint. If you believe that your privacy rights have been violated, you may file a complaint with our practices, privacy officer, or with the secretary of the department of health and human services. All complaints submitted in writing, and you will not be penalized for filing a complaint.
7. Right to provide and authorization for other uses and disclosures. Our practice will obtain written permission from you to disclose information in ways that have not been identified in this notice or are not permitted by these laws.
8. Contact our Privacy officer if you have any questions.

With this signature I acknowledge that I have been given a copy of the privacy notice for this practice, and consent to treatment.

_____

Printed Name **Signature** **Date**

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Authorization to Bill Insurance

□No Insurance: Self Pay Rate- New Patient $250.00 Follow Up: $125.00

Client Name: _____ DOB: _____

Primary Policy Holder Name (if other than patient) _____

Relationship: _____ DOB: _____

Insurance Company: _____ Plan: _____

Policy Number: _____Group Number: _____

Do you have a secondary Insurance? □No □ Yes, if yes

Client Name: _____ DOB: _____

Primary Policy Holder Name (if other than patient) _____

Relationship: _____ DOB: _____

Insurance Company: _____ Plan: _____

Policy Number: _____Group Number: _____

I, the undersigned, hereby certify that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above, I therefore authorize the medical staff and personnel to release my information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not

covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I Understand that any portion of my medical bills that is not covered by my insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

Self-pay rate for initial evaluation payable at the time of service is $250.00, follow up visits (30 minutes) are charged at a rate of $125.00.

_____

Printed Name **Signature** **Date**

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Consent for Telemedicine

Patient Name: _____ DOB: ____/_____/_____

Phone: _____ Email: _____

I understand that Telehealth is a mode of delivering health care services, including psychiatry. Telehealth requires the use of communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and other aspects of a patient's care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychiatric appointments. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my psychiatric provider also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my psychiatric provider, that my Psychiatric appointments and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my psychiatric provider may occur during a telehealth session.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions. (e.g., driving, working, personal interruptions)

5. I understand that at the beginning of each Telehealth session my psychiatric provider is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person appointments. I understand that if my psychiatric provider believes I would be better served by in-person therapy, my psychiatric provider will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other psychiatric providers who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

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8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my psychiatric provider may record the sessions without the other party's written permission.

9. I understand that my psychiatric provider will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my psychiatric provider may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

10. I understand that all telemedicine calls must be done via Doxy.Me or Zoom by a link sent to me by Daily Hope Healthcare Services LLC. I am responsible for ensuring that the device I will use for my telemedicine appointment has accurate signal, and a working camera and microphone, that must be turned on during the duration of my appointment. Link will be sent to me via email, with any paperwork needed for appointment. I agree to fill out any paperwork and email it back no later than 2 hours prior to scheduled appointment.

I have read and understand the information provided above, have discussed it with my psychiatric provider, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Signature: _____ Date: _____/_____/_____

Verbal Consent Obtained

Telehealth Consent Form was emailed to Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychiatric services from Daily Hope Healthcare Services LLC via Telehealth.

_____ _____ ___/____/_____ _____: _____ AM/PM

Staff Signature Title Date Time

622 N COUNTRY CLUB RD. SUITE D, TUCSON AZ 85716
Phone: (520)372-2272 ✦ Fax: (520)336-9163

Coordination of Healthcare

Dear Dr._____,
(PCP Name)
Your Patient _____,
(Patient's Printed Name)
is receiving behavioral health services. This information may be helpful for you in the patient's medical care.

The Current diagnosis is: _____

Medications are being managed by: _____

Current Medications are: _____

_____

Treatment goals include: _____

_____

If you need additional information or have any questions, please contact me at (520)372-2272.

Sincerely,

_____ _____
Tolu Green-Yesu, Psychiatric NP Date

Consent to Release Information

(Pease choose 1 of the □ below)

□Consent to release/exchange information signed below:
□Patient **refused** to authorize communication/ Does not have a PCP**. Do not send form**.
Printed Name: _____ Date: _____

I hereby authorize and or exchange of information with my Primary Care Physician to allow for coordination of care and treatment. I understand this authorization may be revoked by me at any time, except to the extent action has been taken.

_____ _____
Patient Signature Date

For Office Use ONLY
Card Information Collected □

622 N COUNTRY CLUB RD. SUITE D, TUCSON AZ 85716
Phone: (520)372-2272 ✦ Fax: (520)336-9163

Financial Responsibility Agreement

To our patients,

Daily Hope Healthcare Services LLC does not participate in any court proceedings/appearances, further charges may be incurred for additional time spent relative to care (telephone calls, consultations, reports, mailing of records, etc.)

Our self-pay fees for an initial evaluation are $250.00 and follow up, office visits $125.00.

Patient Initials _____ If patient is using insurance, it is the patient's responsibility to verify their outpatient mental health benefits, obtain prior authorization if needed, and verify that Daily Hope Healthcare Services LLC is in network (We do NOT bill out of network insurances)

Patient Initials _____ There also may be a charge for frequent or lengthy (greater than 10 minutes) telephone contact with patients. Insurance carriers will not pay for phone calls, letters or reports, consultations with other doctors/ therapist, and these charges will be the responsibility of the patient and will be billed to the patient directly.

Patient Initials _____ Payments are due at the time if the appointment. (Self-pay, insurance deductibles, co-pays, or co-insurance). NO CASH PAYMENTS. (Check, money order or debit/credit card.)

Patient Initials _____ All late cancellations/ reschedules (24-hour notification required) and/or missed appointments will be charged a $50.00 fee (THESE CHARGES APPLY TO ALL PATIENTS, SELF-PAY OR MANAGED CARE). There will be a $35.00 fee for all returned checks. **THESE FEES REMAIN THE RESPONSIBILITY OF THE PATIENT. Debit/Credit card on File will be REQUIRED for every patient.**

In the event that a patient's account is referred to an attorney for collection the responsible party agrees to pay all responsible attorney and court fees.

I have read the above agreement and wish to continue with the evaluation and treatment. I agree to pay the fees specified above at the time of each appointment.

_____ _____

Patient name: (Please print) **Signature of responsible party**

_____ _____

Date of Birth **Today's date**

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CONTROLLED SUBSTANCES PATIENT AGREEMENT

I,_____understand and voluntarily agree that

(Initial each statement after reviewing):

_____I will keep (and be on time for) all my scheduled appointments with the provider and other members of the treatment team.

_____I will participate in all other types of treatment that I am asked to participate in.

_____ I am responsible for keeping my medicine safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the prescriber or other member of the treatment team.

_____I will not call between appointments, at night, or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will notify the office immediately.

_____I will always treat the staff at the office respectfully at all times I understand that if I am, disrespectful to staff or disrupt the care of other patients, services will be terminated.

____I will not call the office more than once a day for refills. Allowing up to 48 hours for refill to be completed. Calling multiple times for refills will result in termination of services.

____I will not show up at the clinic outside of my regularly scheduled appointment time. All visits are by appointment
only.
_____I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____I will sign a release form to let the provider speak to all other doctors or providers that I see.

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_____I will tell the provider all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____I will use only one pharmacy to get all of my medicines:

Pharmacy name/phone#_____

Due to the ongoing shortage of certain medications, pharmacy changes will be allowed only after it is verified that they have a medication in stock. Future prescriptions will be sent to the main pharmacy.

_____I will not refill medications from other providers including my PCP, if this is done, I understand my treatment will be stopped.

____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment will be stopped.

____Urine drug test might be required at certain times during treatment, lack of compliance with the request will result in discontinuation of services.

____I will keep up to date with any bills from the office and tell the provider or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

___I understand that I may lose my right to treatment in this office if I break any part of this agreement.

☐ I am the parent/guardian of this patient

_____

Printed Name Signature Date