

Arizona Behavioral Health Specialists, LLC

7330 N 16th St suite A-120 Phoenix, AZ 85020

Office: 602-997-6635 fax: 602-997-6642 e-mail: azbehavioral@gmail.com

PATIENT DETAILS

Patient Name: Last _____ First _____ MI: _____

Date of Birth: _____ Social Security Number: _____

Gender: Male Female Other

Physical Address (no PO Box) _____

City: _____ State: _____ Zip Code _____

Home Number: _____ Mobile Phone: _____

Marital Status: Single Married Divorced Separated Widowed

Place of Employment: _____ Work Phone: _____

Email Address: _____ Referred By: _____

RESPONSIBLE PARTY/GUARDIAN INFORMATION

Mother/Guardian Name: _____ DOB: _____

Address (If different than page1): _____

Primary Phone: _____

Father/Guardian Name: _____ DOB: _____

Address (If different than page1): _____

Primary Phone: _____

Who has legal custody of Child? Parents Mother Father Grandparents Other

Are there any custody considerations of which the provider should be aware of? _____

If yes, please provide a copy of the Custody Arrangement.

POLICY HOLDER/PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Policy Holder Name: _____ Relation to Patient: _____

SSN of Policy Holder: _____ DOB of Policy Holder: _____

Member ID: _____ Group: _____

Policy Holder's address: _____

Primary Phone: _____ Secondary Phone: _____

Policy Holder's Employer: _____

SECODARY INSURANCE IF APPLICABLE

Insurance Company: _____

Policy Holder Name: _____ Relation to Patient: _____

SSN of Policy Holder: _____ DOB of Policy Holder: _____

Member ID: _____ Group: _____

Policy Holder's address: _____

Primary Phone: _____ Secondary Phone: _____

Policy Holder's Employer: _____

EAP INFORMATION – Please fill out if using EAP benefits

Name of Insurance EAP is through: _____ Phone Number: _____

Employer of the Insured: _____

Authorization Number: _____ Valid Dates: _____

COORDINATION OF CARE

It is important for your Health Care Providers to speak to each other so that we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

Primary Care Physician: _____ Phone Number: _____

Address: _____ City/State _____ Zip Code _____

May we contact your physician? _____

Psychiatrist/Therapist: _____ Phone Number: _____

Address: _____ City/State _____ Zip Code _____

May we contact your psychiatrist/therapist? _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

Patient/Guardian Signature: _____ Date: _____

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ABHS HIPAA FORM

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. This notice is effective April 14, 2003.

I. It is our legal duty to safeguard the privacy of your health information. We are required to provide you with this notice describing our privacy practices and your rights regarding your medical information. We are required to follow the privacy practices described in this notice. We reserve the right to change our privacy practices. Before any important change is made, we will change this notice and make the new notice available.

II. We will use and disclose your medical information for the following purposes. We will not disclose your medical information for any other purpose not listed below, without your specific written authorization.

- a. **Treatment:** Your medical information may be disclosed to physicians, psychiatrists, psychologists, and other health care providers who provide you with health care services.
- b. **Health Care Operations:** Your medical information may be disclosed for operation of this practice. Example: Quality Control Evaluations or other administrative, financial, or legal activities necessary for our operation
- c. **Payment:** To bill and collect payment for the treatment and services you receive.
- d. **Emergency Situation:** Your medical information may be disclosed if you are in need of emergency treatment and your consent cannot be obtained
- e. **When Legally Required:** Your medical information may be disclosed when required to do so by any Federal, State, or local law,
- f. **Judicial and Administrative Proceedings:** In response to a Court or Administrative Order, Subpoena, or other lawful process, g Worker 's Compensation: To comply with laws related to Worker's Compensation.
- g. **Victims of abuse and neglect reporting laws:** We may disclose your medical information if it is necessary to prevent a serious threat to your health or safety or the health and safety of others.
- h. **Notification:** For appointment reminders.
- i. National Security or Intelligence purposes.

III. Your individual rights regarding your medical information.

- a. The right to request limits on use and disclosure of your medical information. You may request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree with the additional restrictions, but if we do, we will abide by our agreement.
- b. The right to see and get copies of your medical information. If you request copies, you may be charged for each page and postage if you want the copies mailed to you.
- c. The right to choose how your medical information is sent to you. You may choose an alternate address or alternate means of receiving your medical information.
- d. The right to amend your medical information. If you believe there is an error in your medical information or that important information has been omitted, it is your right to request corrections be made or additional information added. Your request and the reason for the request must be made in writing. You will receive a response within sixty days of receipt of your request. If your request is denied, you will be provided with a written explanation. If your request is approved, the changes will be made.
- e. The right to get a list of disclosures of your medical information. The list will not include uses or disclosures to which you have already consented (i, e, for payment), non-disclosures made before April 14, 2003.

- IV. **Questions and Complaints:** If you believe your privacy rights have been violated, or if you object to a decision made about access to your medical information, you are entitled to file a complaint by contacting the ABHS HIPPA Privacy Officer at 602-997-6635, You may also contact the secretary of the Department of Health and Human Services, Anyone who chooses to file a complaint will not be subject to retaliation.
- V. **Acknowledgement:** I have received the Notice of Privacy Practice, and I have been provided an opportunity to review it,

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

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OFFICE PROCEDURES / CONDITIONS OF EVALUATION/ TREATMENT

Welcome to Arizona Behavioral Health Specialists, LLC. Please read the following information carefully, as it contains important information regarding our office policies and your treatment and/or treatment of your child. This form provides you with information that is in addition to that detailed in the notice of privacy practices.

Appointments: All services are rendered by appointment only at a mutually agreed time. Scheduled appointments must be canceled 24 hours in advance, or you will be responsible for a charge, which may be 50% to 100% of the regular appointment fee.

Financial Agreement: You are responsible for supplying all the current and correct billing information (Bank card, credit or HAS card). Including primary insurance information and secondary coverage, to our office at the time of your first appointment. We will bill your insurance as a courtesy to you. Please be aware that most insurance companies require you to obtain authorization prior to the start of treatment. You will be responsible for all charges not covered by your insurance, including any denied charges, any fees, including co-payments and deductibles, are due at the time of service. You will be responsible for any processing fees charged for checks returned by the bank. Please notify our office within ten days of any changes in insurance coverage, address, or telephone numbers. In the event collection / legal efforts are utilized to collect a past due balance, you will be responsible for payment of all fees connected with those efforts. If you require other professional services, such as preparation of reports, letters, telephone consultations, or other correspondence not completed during scheduled appointment times, you will be responsible for any charges. Fees are based on time spent.

Telehealth Appointments: ABHS requires that all patients participating in Telehealth services complete and sign all consent forms prior to receiving services. As part of our financial agreement, a **CARD (bank card, credit, or HSA) ON FILE IS REQUIRED** for all patients who are receiving Telehealth services. Your card will automatically be run for any fees, including: co-payments, deductibles and past due balances, that are due at the time of services. It is the patient's responsibility to notify the office if your information has changed. ABHS, is not responsible for any overdraw fees.

Insurance/Managed Care: Please be aware that many managed health plans are often oriented towards a short-term treatment approach designed to resolve specific problems that are interfering with one's own usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. While short-term treatment can be very beneficial, many clients felt that more sessions are necessary after insurance benefits expire. It is important to remember that you may have the right to pay for services yourself and avoid the complexities associated with insurance reimbursement. You also have the right to self-bill your insurance company for reimbursement of

services (for providers who are not in your insurance network or those not accepting insurance). Your insurance company will supply you with the necessary information needed to self-bill.

If needed, our office will supply you with the necessary information needed for self-billing (Tax ID # and Diagnosis Code) upon request.

Confidentiality: In general, all information shared in treatment is confidential and can only be released with your written permission. However, there are some exceptions, ABHS may disclose all or part of your records to the following third parties for financial reimbursement: insurance companies, workers compensation, government agencies and other fiduciaries. Information is typically limited to diagnosis codes, treatment plan or treatment summaries, and in rare cases, a copy of the entire record. Your treatment may be discussed with another professional in our practice for the purpose of consultation. In these circumstances every effort is made to avoid revealing your identity. It may be necessary to discuss your treatment with your primary care physician or other treating physician for the purpose of providing continuity of care. There are other rare situations where steps may be required to take protective action when there is a threat of serious bodily harm to self or others. Please be advised that if there is an assessed potential for self-harm or harm of others, confidentiality does not exist. These steps may include notifying the potential victim, notifying the police or other agency, family members or seeking appropriate hospitalization. There are other situations in which the law requires action to protect others from harm, such as suspected abuse of a child, elderly person, or disabled person. A report must be made with the appropriate State agency and / or the law enforcement agency under those circumstances.

In the instance of the psychotherapy treatment of a child who is the identified patient, the positive psychotherapeutic process involves that we maintain the confidentiality of the child for a positive treatment process. While the parent or guardian provides consent for evaluation and /or treatment, the confidentiality in this instance is maintained with the child. We will provide pertinent clinical information including diagnosis, recommendations, treatment summaries, and / or verbal or written updates. At the time of visits general clinical information / recommendations may be provided. The exception to confidentiality is if there is any risk to the child such as the potential for self-harm and / or high-risk behaviors. As part of this consent agreement for evaluation / treatment the usual access to treatment records per ARS / Federal (statutes/regulations) is waived by the parent / guardian to have you provided with treatment records. This does not waive your right to have information released to other individuals such as other mental health providers, physicians, and/or education institutions. The therapeutic impact of any request for records will be discussed with you and if you should choose to revoke this waiver, the potential impact on ongoing treatment will be discussed.

Individuals sometimes inquire about mental health professionals providing information related to forensic (legal) actions. Please be advised that you / your child is being evaluated / treated in a clinical setting and that any request for an expert opinion related to litigation will not be provided. That includes issues related to custody, visitation, and / or other court related issues.

Confidentiality of e-mail, SMS messages and fax communication: We are committed to maintaining our client's privacy. Our staff utilizes business practices that may constitute a potential risk to your confidentiality, despite the security measures that we have in place to protect your privacy. These practices include, but are not limited to, use of electronic calendars, use of paper calendars, use of laptop computers, use of computerized billing, use of an internet-based phone system, and use of communication via mail, cell phone, unencrypted email with you and other professionals. SMS Messages: No mobile information will be shared or sold with third parties/affiliates for marketing/promotional purposes. All the stated categories in this privacy policy exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties. End users can opt out of receiving further messages by replying STOP or ask for more details by replying HELP. Message frequency varies. Message and data rates may apply. Please notify us at the beginning of treatment if you have any concerns regarding the use of these communication devices.

Medical Record Request: Patients have the right to request a copy of their health information.

A Medical Release Form IS Usually Needed Before:

- Sharing records with third parties not involved in treatment, payment, or healthcare operations (such as employers, life insurance companies, or attorneys).
- Releasing information to family members who are not legal representatives or healthcare proxies for the patient (such as the mother of a competent adult).
- Disclosing specially protected information like HIV status, substance abuse treatment records, genetic information, or [therapy notes](#).
- Using patient information for commercial purposes or other reasons beyond treatment, payment, or healthcare operations.

A Medical Release Form is NOT Required for:

- **Treatment purposes** - Clinicians directly involved in a patient's care (such as in an MDT) may share information without requiring separate medical release forms.
- **Payment operations** - Sharing information with insurance companies for billing purposes usually doesn't require a medical release of information form.
- **Healthcare operations** - Patient information may be used for quality assessment, audits, medical reviews, or other administrative functions.
- **Emergencies** - Medical information can be shared to facilitate immediate treatment when obtaining consent would delay life-saving care.

Breaching Confidentiality Due to Risk: Clinicians sometimes face scenarios where maintaining confidentiality conflicts with a duty to protect the patient or others from harm. These situations may justify (or require) releasing confidential health information (like a mental state examination) without authorization from the patient.

For Example:

- When the patient poses a serious and imminent risk to themselves or others
- When required by law or court order
- Disclosing information to protect adults who lack decision-making capacity

- When there is a public interest in disclosure (such as the prevention, detection, or prosecution of a serious crime)
- US clinicians are similarly bound by the [duty to protect principle](#), which stipulates (via legal precedents) that mental health professionals have a duty to protect potential victims from violent acts by their patients.

Record Retention:

- As mandated by Arizona Revised Statute § 12-2297, all medical records will be retained for a minimum of seven years after the last date you received medical or health care services from this provider.
- If the patient is a child, either for at least three years after the child's eighteenth birthday or for at least seven years after the last date the child received medical or health care services from that provider, whichever date occurs later.
- When a health care provider retires or sells the provider's practice, the provider shall take reasonable measures to ensure that the provider's records are retained pursuant to this section. An effort should be made to notify the patient within 30days of the date of change.

Your signature below indicates you have read our policies carefully, understand them, and agree to be bound by them during and after treatment at Arizona Behavioral Health Specialists, LLC. Your signature will further authorize Arizona Behavioral Health Specialists to conduct an evaluation and perform treatment for you and / or your dependent child with regard to psychological or behavioral health problems. If you are seeking treatment for your child, we may also request that the other parent provide consent for evaluation / treatment.

Patient/Guardian Signature

Date

If a patient is a minor, biological parent or legal guardian must sign this form. If you are not the biological parent or legal guardian, please notify our office staff immediately as your appointment may have to be rescheduled. If you have guardianship, please provide us with documentation. We may also ask you to provide a copy of a divorce decree if pertinent.

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Telepractice Informed Consent Form

I _____ hereby consent to engage in telepractice contact with Therapist. I understand that “telepractice” includes consultation, treatment, transfer of medical data, emails, text messages, telephone conversations, and education using interaction audio, video, and/or data communication. I understand that telepractice can also involve the communication of my medical or mental information, both orally and visually.

I understand that I have the following rights with respect to telepractice:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. However, if therapy is Court ordered, the Court will be notified and may issue further orders or consequences.
2. The laws that protect the confidentiality of my medical information also apply to telepractice. As such, I understand that the information disclosed by me during the course of pre-therapy discussions and/or therapy consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Psychotherapy Services Agreement I received with this consent form. If therapy is Court ordered, the Court will determine access to such medical information.
3. I understand that I may benefit from participating by telepractice, but those results cannot be guaranteed or assured.
4. I accept that telepractice with Therapist does not provide emergency services. During our first session, my therapist and I will discuss an emergency response plan. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800. 273.TALK (8255) for free 24-hour hotline support.

5. I understand that I am responsible for (a) providing the necessary computer, telecommunications equipment and internet access for my telepractice sessions, (b) the information security on my computer or other device, and (c) arranging a location with sufficient lighting and privacy that is free from distractions for any telepractice session.
6. I understand that while audio, video, data transfer, email and text messaging may be used to communicate with my therapist, the confidentiality of such methods cannot be guaranteed. Risks include technology interception and hacking.
7. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.
8. The identity of a client receiving telepractice services, other than by video, will be verified by means of the client providing their name and a unique identifier. That unique identifier will be issued by Therapist to a client qualifying for receipt of Telepractice services from therapist.
9. I agree to these safeguards in order for my client electronic communication to be received only by my therapist.
 - My client electronic communication will be addressed only to my specific therapist.
 - I will only use a device personal to me, which is not used by other people, to electronically communicate with my therapist.
 - My therapist will access electronic communication from me only on a device with security approved by the Therapist.
 - Both my Therapist and I will access electronic communication with each other in locations with sufficient privacy so as not to compromise confidentiality.
10. I understand that telepractice is an innovative service that may not provide as complete care as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services), I will be referred to a professional who can provide such services in my area. I further understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.
11. I accept that there is inherent confidentiality risks associated with the is for technology. The transmission of my information could be interrupted by unauthorized people. The electronic storage of my personal health information could be accessed by unauthorized people.

12. I accept that there is a potential risk of technology failure that may disrupt or prevent the provision of telepractice services. If disruption occurs, communication may attempt to be reestablished by either me or my therapist, repeating the process used to initiate communication. Despite reasonable efforts on the part of my therapist. The transmission of my information could be distorted by technical difficulties.
13. I understand that my therapist will usually respond to routine emails, text, fax, or telephone communications from a client within 24 hours by using the same communication method that the client used. My therapist may also respond using an alternative or equivalent communication method or by trying to use a method of response specifically requested by me. I further understand that Therapist does NOT use Snapchat for communication with clients.
14. I realize that alternative means of communication may be used in emergencies or when other methods of communication do not appear to be working.
15. I understand that Therapist may have administrative and office staff that assist Therapist with scheduling, billing, and documentation issues. My electronic communications, particularly those regarding scheduling, billing, and documentation, may be accessed by administrative and office staff.
16. I accept that there is no permanent video or voice recording kept by Therapist of a telepractice session. Instead, a progress note is made by Therapist of a telepractice session and retained as part of the stored client records in a security approved system. Copies of emails, text messages, and faxes between client and Therapist are also stored.
17. I understand that Therapist uses the following type of secure electronic technology for Therapist to communicate with client: **Therapy Appointments Portal.**

I have read, understand and agree with the information provided above.

x _____

Client (or Guardian's) Signature

Date

x _____

Printed Name

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Patient Name: _____

Patient Date of Birth: _____

I am authorizing Arizona Behavioral Health Specialists to keep my credit card number on file and charge my credit card for each visit. This includes, but is not limited to: Co-pays, deductibles, account balance that are more than 30 days overdue, late cancel fees, no show fees and fees for letters and forms. If my credit card information changes, I will call to notify ABHS of these changes and allow 3 business days for the change to take effect.

Credit Card Number: _____

Expiration Date: _____ V Code: _____

Name (as it appears on card): _____

Please Print

Signature: _____ Date: _____

BILLING ZIP CODE _____