Robert Schulte, MD
Board Certified Child, Adolescent & Adult Psychiatrist

8776 E. Shea Blvd, Ste 106-1024, Scottsdale, AZ 85260
Phone: (480) 451-3454 Fax: (480) 451-.3453
Email: contact@robertschultemd.com

NEW PATIENT INTAKE PACKET

Today's Date ______________________________ *Referred By* ____

Patient's Name (Last, First, MI) ____

Birth Date_________-_________-__________Age_________Gender: M / F SS#_________-______- _________

Address_____________________________________City______________________State_______Zip __________

Preferred Contact Number______________________Secondary Contact Number _________________________

Email:(We will use this for reminders unless you specify otherwise)____________________________________

Alternate/Emergency Contact______________________________Preferred Phone_________________________

Primary Physician___________________________________Phone____________________Fax _______________

Pharmacy____Phone___________________Fax _______________

Therapist (if applicable)_______________________________Phone__________________Fax _______________

Marital Status:______Married______Single______Widowed______Divorced______Separated_______#Yrs

Name of Spouse/Significant Other/Parent(s)____

Names & Ages of Children/Siblings____

If a patient is a minor please complete the following:

Mother's Name____Preferred Phone________________________
Alternate Phone ________________________

Address_____________________________________City______________________State_______Zip __________

Father's Name____Preferred Phone________________________
Alternate Phone________________________

Address_____________________________________City______________________State_______Zip __________

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BILLING INFORMATION:

Party responsible for payment______________________Responsible Party phone ______________________

Responsible Party Address ____
Number Street City State Zip Code

Insurance Information (**Please Note**: We gather insurance information for the purpose of expediting coverage for your prescriptions. Some insurance carriers require prior authorization to cover medications and will require us to submit forms on your behalf to secure approval. ***We do not contract with insurance for any services.***)

Carrier Name_______________________________Member / Patient ID ______________________________

Group ID__________________________________Customer Service #_______________________________

BILLING & ATTENDANCE POLICIES:

• **ALL PAYMENTS ARE DUE AT TIME OF SERVICE.** While we do not contract with or submit to insurance, we will provide you with a one page "Superbill" with all the necessary information for you to submit to your insurance company for reimbursement upon request.

• Phone consultations and or letters/forms will be charged as follows: 5-10 min is $190, 11-20 is $290, and half hours are $340. Multiple calls will be aggregated per 24 hour period. Declined credit card charge is $140.

• **PATIENTS/ GUARANTORS MUST MAINTAIN CURRENT A CREDIT OR DEBIT CARD ON FILE.** This information will only be used for actual charges incurred, including phone consults, requested reports, and *missed or late-canceled appointments*. You are always welcome to use an alternate form of payment so long as it is offered at time of service.

• There is a 24 hour cancellation policy for Tuesday through Friday appointments. Monday appointments must be canceled by 2pm on the previous Friday. **FULL SESSION FEES ARE CHARGED TO YOUR CARD ON FILE FOR ALL MISSED OR LATE-CANCELLED APPOINTMENTS.**

• While we do try to make courtesy reminders, clinical matters take precedence and we are not always able to do so. **PLEASE KEEP TRACK OF YOUR APPOINTMENTS TO AVOID MISSED APPOINTMENT CHARGES.**

I have read, understand, and agree to abide by the foregoing billing & attendance policies. I understand that the foregoing agreement is binding in the state of Arizona. I hereby give express permission to Robert Schulte, MD (or his staff at his direction) to charge my card on file for charges incurred where I have not previously or simultaneously arranged alternate payment. I understand that I will be emailed a credit card receipt and Superbill detailing said charges within 24 hours after being charged upon request.

______________________________________ ______________________
Responsible Party Signature Date

______________________________________ ______________________
Witness Date

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PHYSICIAN-PATIENT AGREEMENT

This agreement serves to inform Dr. Schulte's patients regarding office policies, physician policies, and the Physician-patient relationship. Please read this agreement in its entirety and sign where indicated to acknowledge your understanding of this agreement and to abide by the policies contained therein.

ATTENDANCE POLICY: Dr. Schulte requires that all patients taking CII medication (generally, stimulants) be seen every three months and that those taking CIV medications (generally, benzodiazepines) to be seen every 4 months. All others on medication should generally be seen not less than every 6 months. Failure to maintain a regular attendance schedule may affect your ability to receive refills in a timely manner.

PRESCRIPTION POLICY: For REFILLS please contact your pharmacy directly; they will initiate the proper procedure. ****Please make sure to allow sufficient time for processing on all prescriptions, especially on weekends, so that you do not run out of your medication.****

CONFIDENTIALITY POLICY: Please see attached "**Arizona Notice Form**."

RE: THE MEDICAL INFORMATION BUREAU: Health insurance policies sometimes require patients to release all encounter information for any service rendered that is claimed against the health care plan. The diagnosis and treatment information required on the claim form is often then forwarded to the Medical Information Bureau (MIB), where it becomes available to other insurance companies without the patient's knowledge or consent. For this reason, Dr. Schulte cautions all patients that the release of any information through the claims filing process *may* present a potential risk that could be personally damaging to unknowing patients should an inappropriate party gain access to the MIB national database.

MEDICARE PART B ENTITLEMENT POLICY: While Dr. Schulte will gladly treat patients who are Medicare eligible, he does not participate in the Medicare Part B program. Unfortunately, this means that Medicare eligible patients are not allowed to seek Medicare reimbursement for Dr. Schulte's services and are required by law to sign a "waiver of Medicare Part B entitlement" acknowledging the same. A waiver is included in this packet and will need to be signed prior to receiving services.

PATIENT/PHYSICIAN RESPONSIBILTIES: Each patient is responsible for providing accurate contact and billing information. If a patient's telephone, email, or address changes it is the duty of that patient to inform Dr. Schulte's office immediately to avoid disruption of communication.
Examination and treatment provided by Dr. Schulte is limited to outpatient psychiatric services. The patient should be aware that this does not necessarily constitute total or definitive psychiatric care, and that further evaluation and treatment may be required in some cases. It is the patient's responsibility to obtain follow up medical care for general health as needed or where when advised to do so by Dr. Schulte. The patient further acknowledges that psychiatry is a specialty within the field of medicine and is not meant to be a substitution for primary medical care.

TERMINATION POLICY: Dr. Schulte reserves the right to terminate any patient who violates treatment protocol, is generally non-compliant (with respect to treatment directives or office policies), willfully disregards treatment objectives that are designed to obtain positive clinical outcomes, or is rude or disrespectful to him or his staff. He will continue to treat the terminated patient on an *emergency basis only* for 30 days after termination.

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STORAGE, TRANSFER & ACCESS TO PATIENT RECORDS ON TERMINATION OF THE PRACTICE:

In the event of the termination of Dr. Schulte's practice, the doctor (or a designee from his staff) will post two notices in the Arizona Republic, two weeks apart, regarding the close of the practice and information for locating medical records. The doctor or his staff designee will further advise all active clients (by letter or direct verbal communication) where and how they may contact the doctor for purposes of interim/transfer care or to request their records. Patients will be provided either a phone number to contact the doctor directly or with numbers for the Arizona State Psychiatric Association or the Arizona State Medical Board, who will be able to properly direct requests (the doctor will maintain current contact with both associations during the required period for records retention). The doctor will maintain a professional telephone contact number for a period of three to six months, depending on circumstances surrounding the closure of the practice.

To protect personal privacy, the doctor or his staff designee will only provide direct access numbers to active or recent (6-month inactive) patients. *Inactive* patients will be able to direct records requests to the Arizona State Psychiatric Association or the Arizona State Medical Board. The doctor will maintain records at:

North Scottsdale Psychiatric Specialists
8776 E. Shea Blvd, Ste 106-1024
Scottsdale, AZ 85260

The doctor or his staff designee will respond in a timely manner to patient requests for copies or access to their medical records. Unless prohibited by illness, temporary travel unavailability, or death the doctor will respond within 30 days or other legally or ethically mandated time frame. The doctor or his staff designee will dispose of unclaimed records after the legally specified time for retention by destroying said records such no confidential information remains in useable form.

In the event that circumstances require, the doctor or his staff designee will forward access and responsibility to another professional who will respond to records requests in accordance with legal and professional standards as set forth by the Arizona State Psychiatric Association and the Arizona State Medical Board.

I have read, understand, and accept the provisions of this Physician-Patient Agreement, and have no questions about the policies outlined herein. I understand that if I violate any provisions of this agreement my treatment may be terminated. I understand that this agreement is binding in the state of Arizona and that the provisions herein are for my protection and the protection of Dr. Schulte. The original, signed agreement will become part of my private medical record and I am entitled to a copy at my request.

____ ____________________
Patient signature Date

____ ____________________
Witness signature Date

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AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I, (name of or parent/guardian if a minor)________________________________, hereby authorize Dr. Robert Schulte to obtain information from and release information to:

____

____

____

Patient Name:____Date of Birth: ____________________________

Reason for release:

( ) My request ( ) Coordination of Care ( ) Transfer of Care

( ) Other ____

Portion of record to be released:

( ) All ( ) Diagnostic Evaluation ( ) Verbal Contact ( ) Diagnostic Test Reports

( ) Summary of Contact with Client ( ) Other (specify) ____

I understand why this information is needed and I am satisfied that it will be held confidential. Photocopies of this form will be considered as valid as the original. This authorization will remain in effect until revoked by me in writing or upon termination of care with Dr. Schulte.

Signed____Date___________________________

Witness____Date___________________________

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Acknowledgment of Receipt of Notice of Psychiatrist's Policies and Practices to Protect the Privacy of Your Health Information

I,_______________________________________acknowledge that I have been given a copy of Dr. Robert Schulte's Notice of Privacy Practices. This Notice describes how Dr. Robert Schulte may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I understand these policies and agree to abide by / give consent for the same.

____ ____________________
Signature of patient or representative Date

____
Relationship to patient

____ ____________________
Witness Date

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Waiver of Medicare Part B Entitlement

I have voluntarily decided to contract privately for services outside the Medicare Part B program. Neither I, nor my family, nor my heirs, nor my estate shall file any Medicare Part B claims or forms. Further, I neither require nor request that Robert Schulte, M.D. or his office staff to do so on my behalf. I hereby waive my entitlement to Medicare Part B benefits for all services rendered by Robert Schulte, M.D.

____
Medicare Eligible Patient Name (Printed)

____
Medicare ID Number (if applicable)

____
Eligible party Signature

____
Date Signed

____
Witness Name (Printed)

____
Witness Signature

____
Date Signed

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Confidential Patient Medical History

Please provide the following information about your general health and your health history. Enter **P** for personal history and **F** for family history.

_ALCOHOL OR DRUG USE ALLERGIES;
_MEDICATIONS
_ALLERGIES; POLLEN, DUST, ANIMALS
_ANXIETY
_ARTHRITIS; GOUT
_BACK, NECK, SPINE, DISC PROBLEMS/INJUR
_BIRTH DEFECTS/DEFORMITY
_BONE/JOINT CONDITION
_BLOOD DISEASE; ANEMIA, LUKEMIA
_BREAST DISEASE
_BREAST IMPLANTS (L/R)
_BLOOD VESSEL, CIRCULATION DISORDER
_BROKEN BONES/BONE DISEASE
_CANCERS OF ANY TYPE
_COLON/CROHN'S DISEASE
_CONCUSSION/HEAD INJURY
_DIABETES
_EAR/NOSE/THROAT DISEASE OR INFECTION
_EATING DISORDER; ANOREXIA, BULIMIA
_EPILEPSY/SEIZURE DISORDER, CONVULSIONS
_FEMALE ORGAN IRREGULARITY; ABNORMAL PAP
_ALLBLADDER DISEASE
_HEART DEFECT OR CONDITION
_HEPATITIS/LIVER DISORDER
_WEIGHT PROBLEMS
_HERNIA
_HIV/AIDS
_HORMONAL/THYROID/PITUITARY
_HYPERTENSION/BP DISORDER
_HYSTERECTOMY
_IMMUNE SYSTEM DISORDER, LUPUS
_INTESTIONAL DISORDERS
_KIDNEY/URINARY TRACT CONDITION OR
_INFECTION
_MALE ORGAN IRREGULARITY/IMPOTENCE
_MENSTRUAL PROBLEMS
_MENTAL: NERVOUS, DEPRESSION
_MIGRAINES/HEADACHES
_MUSCLE/TENDON DISORDERS
_NERVOUS SYSTEM CONDITIONS
_PROSTATE DISEASE/CONDITION
_PROSTHETIC IMPLANT/ ARTIFICIAL LIMBS
_RECONSTRUCTIVE/COSMETIC SURGERY
_SEXUALLY TRANSMITTED DISEASE
_SKIN DISORDERS/LESIONS/CANCER
_STEROID USE; PREDNISONE/ANABOLIC
_STOMACH
_STROKE
_TUMORS, CYSTS, POLYPS, GROWTHS
_ULCERS, DIGESTIVE DISORDERS
OTHER, EXPLAIN ________________________

Current and Past Medications (please list current and past medications)

Current	Past

If you have any history of substance abuse, please indicate:

	Current	Past		Current	Past
Alcohol			Cocaine		
Hypnotics			Anxiety Pills		
Tobacco			Marijuana		
Diet Pills			Sleeping Pills		
Caffeine			Stimulants		
Narcotics/Pain			Others (Specify)		

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Do you have any medication allergies/sensitivities? If yes, which medications are you allergic or sensitive to?

____

Please list any other substances you have allergies to, such as foods or over-the-counter medications:

____

____

Have you ever been hospitalized? If yes, please state when, where, and why:

____

____

____

Have you ever had surgery? If so, please state the type of surgery, when, where, and why:

____

____

Has there been any family psychiatric history? If yes, please explain:

____

____

Do you have any legal history that may be applicable (arrests, lawsuits, etc.). If so, please describe:

____

____

Please check any of the following areas that you have experienced:

[ ] Head injury [ ] Loss of consciousness [ ] Seizures [ ] Convulsions [ ] Other neurological diagnosis

Have you ever smoked?______Yes______No If yes, number of years:_______Daily use:____________________

If female, date of last menstrual period:_____________________ Are you pregnant?________Yes________No

Current Height: ___________ Current Weight: _____________

Blood Pressure History:________High________Normal________Low BP Range (if known):______________

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CONFIDENTIAL PATIENT SOCIAL HISTORY

Highest grade/Degree completed:____________________________________Where? ______________________

How many hours per week do you work?_____________Do you enjoy your work?____ Yes ____No

If retired, do you engage in activities outside your home? ____

What is your household constellation? Do all of your children live with you?

____

____

How often do you spend time with others? ____

____

____

What precipitated this visit? (Feel free to use the back of this page or request more paper)

____

____

____

____

____

Please briefly describe your family as you were growing up:

____

____

____

____

____

____

Please list any events from your childhood/adulthood that have had a profound effect on your life:

____

____

____

____

____

____

____

____

Please describe any areas of conflict in your life (e.g..: work, children, spouse):

____

____

____

____

____

____

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IF THE PATIENT IS A CHILD OR ADOLESCENT, PLESAE COMPLETE THE FOLLOWING:

At what age did problems begin?____

Does the child get along with siblings?____

Describe any difficulties the child has or has had at school?_____________________________
____
____

Has the child been held back any grades? Y N Has the child been in any special classes? Y N

Has any psychological testing been done at school?______________________________

Has the child ever been in legal trouble?______________________________________
____
____
__

Has the child had issues with drug or alcohol use?_________________________________

Did either parent experience any similar conditions as children? ___________________________
____
____

Aside from the condition(s) listed above, has the child ever behaved in any way that seemed especially different or unusual?

____
____
____
____
____
____

Please list persons living at home where the child lives (name, age, relationship to child):

____
____
____

Natal Development:

Describe any problems mother had during pregnancy and / or difficulties with delivery: ______________
____
____

Birth Weight _______________ Oxygen needed? Y N Incubator? Y N Blood transfusions? Y N

Abnormalities:____When developmental milestones met?

Verbal: ______________________________ Motor: ______________________________

Arizona Notice Form

Notice of Psychiatrists Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHIATRIC 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

I 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 I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychiatrist.
  -*Payment* is when I obtain reimbursement for your health care. Examples of payment are when I 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 my 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 my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I 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 I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy Notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I 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) I 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 Disclosure with Neither Consent nor Authorization

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

- *Child Abuse*- I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- *Adult Domestic Abuse*- If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I 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 Psychiatric Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena 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 I provided you and/or the records thereof, such information is privileged under state law, and I 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 of Safety*- If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I 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 I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation* – I 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 Psychiatrist'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, I am 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 at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I 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 my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you 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. I may deny your request. On your request, I 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 you request, I 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 me upon request, even if you have agreed to receive the notice electronically. When requesting a copy of your chart the following will be applied:

The fee is determined consistent with Arizona Revised Statute § 12-351-(F)(1), those charges are as follows:

1. Ten cents ($0.10) per page of standard reproduction of documents
2. Actual cost for reproduction of documents requiring special process
3. Ten dollars ($10.00) per hour per clerical cost.

Psychiatrist's Duties

- I am required by law to maintain the PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide a notice to you via mail and require a signature of receipt an understanding to be returned to my office.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact my office manager at 480.451.3454.

If you believe that your privacy right has been violated and wish to file a complaint with me/my office, you may send your written complaint to myself or my office manager at:

10210 N. 92nd St.,Ste 303
Scottsdale, AZ 85258

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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

This notice will go into effect on June 15th, 2003.