Welcome

Let's Get Started

We are delighted you found us and honored that you've chosen to embark on your well-being journey with Robert Schulte, MD. Before we begin, we kindly ask all new patients to complete the attached form, which will only take about ***15 minutes of your time***. This will help us understand how Dr. Schulte can best assist you.

Form Filling Instructions:

- **Begin Filling Out: Tap on any field in the form, follow the blue "Next" arrow for all required fields.**
- **Non-Applicable Fields: If there is information that does not apply to you, please enter "DOES NOT APPLY" or "N/A".**

Adding a Signature:

- **Signature Field: All signature fields are required**
- **Initials Requirement: Ensure the patient's or parent/guardian's initials are included on the Arizona Disclosure and Privacy Notice.**

Saving and Submitting the Form:

- **Email your form to: contact@robertschultemd.com**
- **Fax your form to: (480) 451-3453**

Helpful Tips

- **Double Check All Fields: Before submitting, make sure every required field is filled in.**
- **If you need more room to answer or provide additional information, please use page 16. Make sure to reference the question and the corresponding page number when doing so.**
- **Need Help? If you run into any issues, don't hesitate to contact our administration care team. We're here to assist you! (480) 451-3454**

Thank you!

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: Femal 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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Arizona Disclosure and Privacy Notice

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

With your consent, I may use or disclose your protected health information (PHI) for treatment, payment, and healthcare operations purposes. Here are some definitions for clarity:

- **PHI**: Information in your health record that can identify you.
- **Treatment, Payment, and Health Care Operations**:
  - **Treatment**: Providing, coordinating, or managing your health care. For example, consulting with another health care provider like your family physician or another psychiatrist.
  - **Payment**: Obtaining reimbursement for your health care. This includes disclosing your PHI to your health insurer to get reimbursement or determine eligibility or coverage.
  - **Health Care Operations**: Activities related to the performance and operation of my practice. Examples include quality assessment, business-related matters like audits, administrative services, and case management and care coordination.
- **Use**: Activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **Disclosure**: Activities outside of my office, such as releasing, transferring, or providing access to your information to other parties. Int.__________

II. Uses and Disclosures Requiring Authorization

For purposes outside of treatment, payment, or healthcare operations, I will obtain your written authorization before using or disclosing your PHI. An “authorization” is additional written permission for specific disclosures. This is also required for releasing your psychotherapy notes, which are notes from our sessions that are kept separate from your medical record and are given greater protection. You can revoke authorizations at any time in writing, except if I have already relied on that authorization or if it was obtained as a condition of obtaining insurance coverage. Int,_________

III. Uses and Disclosures Without Consent or Authorization

I may use or disclose PHI without your consent or authorization in certain circumstances, such as:

- **Child Abuse**: Reporting PHI to authorities if there's reasonable belief of neglect or abuse of a minor (Arizona Revised Statutes § 13-3620).
- **Adult Domestic Abuse**: Disclosing PHI if an incapacitated or vulnerable adult is believed to be neglected, abused, or exploited (Arizona Revised Statutes § 46-454).
- **Health Oversight Activities**: Disclosing PHI to the Arizona Board of Psychologist Examiners during an investigation upon receiving a subpoena (Arizona Revised Statutes § 32-2081).
- **Judicial and Administrative Proceedings**: Releasing information if involved in a court proceeding, under state law, with written authorization or a court order (Arizona Revised Statutes § 32-2081).
- **Serious Threat to Health or Safety**: If there's an explicit threat of harm or risk of self-harm, I may disclose information to prevent harm, including informing potential victims and the police (Arizona Revised Statutes § 32-2084).
- **Worker's Compensation**: Disclosing PHI as necessary to comply with laws related to worker's compensation (Arizona Revised Statutes § 23-908). Int.________________

IV. Patient's Rights and Psychiatrist's Duties

Patient's Rights

- **Right to Request Restrictions**: Request restrictions on uses and disclosures of PHI (though not guaranteed).
- **Right to Confidential Communications**: Receive PHI communications by alternative means at alternative locations.
- **Right to Inspect and Copy**: Access and copy your PHI in mental health and billing records, with some exceptions.
- **Right to Amend**: Request amendments to PHI in the record.
- **Right to an Accounting**: Receive an accounting of disclosures of PHI.
- **Right to a Paper Copy**: Obtain a paper copy of this notice upon request.

Psychiatrist's Duties

- Maintain PHI and provide notice of legal duties and privacy practices.
- Abide by the terms of the current privacy policy unless notified of changes.
- If I revise my policies and procedures, I will provide a notice to you via mail and require a signature of receipt and understanding to be returned to my office. Int.__________

V. Questions and Complaints

For questions or concerns about your privacy rights, contact my office manager at 480.451.3454. If you believe your privacy rights have been violated, you can file a complaint with my office. Or you may send your report to:

Arizona Board of Psychologist Examiners
1740 West Adams Street, Suite 3403, Phoenix, AZ 85007
Phone: (602) 542-8162 Int._______

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

This notice is effective as of July 1st, 1997

NORTH SCOTTSDALE PSYCHIATRIC SPECIALISTS
8776 E. Shea Blvd, Ste 106-1024, Scottsdale, AZ 85260
PHONE: 480.451.3454 FAX: 480.451.3453
EMAIL: contact@robertschulte.com
WEB: http://robertschultemd.com Int_______

______________________________ ______________________________
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
_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?

I ____

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 If yes, number of years:_______Daily use:___________________

If female, date of last menstrual period:____________________ Are you pregnant? 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? NO

Has the child been in any special classes? NO

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? NO Incubator? NO Blood transfusions? NO

Abnormalities:____________________ When developmental milestones met?

Verbal: ________________ Motor: ________________

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Please use this section to provide any additional information. If it pertains to a specific question or if there is something you'd like Dr. Schulte to know, please enter it here. Be sure to include the page number and reference the question.