Psychiatric & Psychological Affiliates of Scottsdale, PLC

14301 N. 87th Street, Suite 112 • Scottsdale, AZ 85260
Tel. 480.609.0001 Fax. 480.607.2790

PATIENT IDENTIFICATION FORM

Name: _____
Last Name First Name Middle Initial

Today's Date: _____

Current Mailing Address: _____
Street

_____
City State Zip Code

Telephone Numbers:
Home: _____
Work: _____
Cell: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Reason for Referral: _____

Referred By: _____

Sex:
( ) Male
( ) Female

Marital Status:
( ) Separated ( ) Widowed
( ) Married ( ) Single ( ) Divorced

Date of Birth: _____

Age: _____

IF MINOR CHILD AND PARENTS NOT LIVING TOGETHER:

Father's Name: _____

Address: _____
Street

_____
City State Zip Code

Telephone Numbers:
Home: _____
Work: _____
Cell: _____

Mother's Name: _____

Address: _____
Street

_____
City State Zip Code

Telephone Numbers:
Home: _____
Work: _____
Cell: _____

Consent for Treatment:

_____ _____
Patient Date

_____ _____
Mother/Guardian Date

_____ _____
Father/Guardian Date

Psychiatric & Psychological Affiliates of Scottsdale,

PLC

14301 N. 87th Street, Suite 112 • Scottsdale, AZ 85260
Tel. 480.609.0001 Fax. 480.607.2790

OFFICE POLICIES AND CONSENT FOR TREATMENT FORM
SABA MANSOOR, MD

Patient Name: _____

In order for you to be treated by Dr. Saba Mansoor you must complete this form.

FEES FOR SERVICES: (Fees may be subject to change)

Please note, fees for preparation of letters, forms, reports and telephone calls will be billed at the same rates as appointments, based on preparation time needed by the clinician/physician.

Initial Eval (1 ½ hr): $395 **Follow-up (20 min): $150**
Returned Check Fee: $25

Additional 15 min blocks of time will be added to your appointment rate at $75.

DIVORCE/CUSTODY:

The parent and/or legal guardian who brings the child in for medical/mental health services will be required to pay the bill. We do not bill third parties regardless of what legal decrees or custody documents indicate. Please, make appropriate arrangements prior to each office visit.

I authorize Dr. Saba Mansoor to charge my credit card for any amount/fees owed for all appointments, including those missed. This includes fees for any appointments that I have failed to keep and have not cancelled or rescheduled 24 hours prior to the appointment time.

Credit Card # _____ Expiration Date: _____ CVV: _____ Billing Zip: _____
( ) Discover ( ) Visa ( ) MC ( ) AmEx

I understand that Dr. Saba Mansoor does not participate with my insurance plan (including Medicare and Medicaid) and I am fully responsible for payment at time services are rendered. I also understand that I am responsible for submitting my claims to my insurance plan.

_____ _____
Patient/Guardian Signature Date

Psychiatric & Psychological Affiliates of Scottsdale,

PLC

14301 N. 87th Street, Suite 112 • Scottsdale, AZ 85260
Tel. 480.609.0001 Fax. 480.607.2790

HIPAA PRIVACY POLICY ACKNOWLEDGEMENT/AGREEMENT

This notice describes how your health information, as a patient of Psychiatric and Psychological Affiliates of Scottsdale, PLC may be used and disclosed, as well as 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 (HIPAA).

Our commitment to your privacy: Your clinician 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 information:

Use and disclosure of your health information in certain special circumstances: (The following circumstances may require your clinician to use or disclose your health information.)

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. IF required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat and protect from harm.
5. If you are a member of the U.S. or a 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 correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
8. For Workers Compensations and similar programs.

Your rights regarding your health information:

1. Communications: You can request that your clinician 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 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 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 record and billing records, but not including psychotherapy notes. You must submit your request in writing to your clinician at: **14301 N. 87th Street, Suite 112, Scottsdale, AZ 85260**.
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 for your clinician. To request an amendment, your request must be made in writing and submitted to your clinician at: **14301 N. 87th Street, Suite 112, Scottsdale, AZ 85260**.
5. Filing a Grievance: You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with your clinician or with the Secretary of the Department of Health and Human Services. To file a complaint with your clinician, please submit in writing to your clinician at: **14301 N. 87th Street, Suite 112, Scottsdale, AZ 85260**. Please note, you will not be penalized for filing a complaint.
6. Right to a copy of this notice at any time: You are entitled to receive a copy of this Notice of Privacy Policies. You may ask us to give you a copy at any time. To obtain a copy of this notice, contact your clinician's front reception desk.
7. Right to provide an authorization for other uses and disclosures: your clinician will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our Health Information Privacy Policies, please contact your physician/clinician at 480.609.0001.

Please, sign the second page of this Privacy Policy to acknowledge your receipt of this information.

Thank you,
Psychiatric and Psychological Affiliates of Scottsdale, PLC

Psychiatric & Psychological Affiliates of Scottsdale, PLC

14301 N. 87th Street, Suite 112 • Scottsdale, AZ 85260
Tel. 480.609.0001 Fax. 480.607.2790

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY (HIPAA) AGREEMENT

Patient Name: _____

I acknowledge that I have received a copy of **Psychiatric & Psychological Affiliates of Scottsdale, PLC**'s "HIPAA Privacy Policy Acknowledgement Agreement" form.

This notice describes how **Psychiatric & Psychological Affiliates of Scottsdale, PLC** 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.

_____ _____
Patient Date

_____ _____
Patient Representative Date

_____
Relationship to Patient

_____ _____
Witness Date

Psychiatric & Psychological Affiliates of Scottsdale,

PLC

14301 N. 87th Street, Suite 112 • Scottsdale, AZ 85260
Tel. 480.609.0001 Fax. 480.607.2790

VERBAL & WRITTEN DISCLOSURE AUTHORIZATION

Patient Name: _____ **DOB:** _____

I do hereby request and authorize Psychiatric and Psychological Affiliates of Scottsdale, PLC to be able to contact the following people or organizations for the purpose of "Facilitation of Treatment."

( ) Saba Mansoor, MD ( ) Jamie Picus, PsyD

Names and relationships of who may be contacted are: **Additions/Deletions**

Parent/Guardian	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Parent/Guardian	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Physician	Phone	Date	Parent Initials	Patient Initials	Staff Initials
School Counselor	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Psychologist/Therapist	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Psychiatrist	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Family/Significant Other	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Probation/Parole/Pretrial Officer	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Other	Phone	Date	Parent Initials	Patient Initials	Staff Initials

I understand that the verbal and written exchange of information may include reference to diagnostic impressions and/or treatment of alcohol/drug use and emotional illness. I understand that my consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon. This consent will remain in effect for the duration of treatment with provider(s) above.

The information disclosed to the authorized parties is from treatment which confidentiality is protected by Federal Law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations prohibit further disclosure of this information without specific written consent of the person to whom it pertains.

Patient Signature	Date	Initials
Parent/Guardian Signature	Date	Initials
Witness	Date	Initials

Psychiatric & Psychological Affiliates of Scottsdale,

PLC

14301 N. 87th Street, Suite 112 • Scottsdale, AZ 85260
Tel. 480.609.0001 Fax. 480.607.2790

Patient Name: _____ **DOB:** _____

CONSENT TO TREATMENT AGREEMENT

Welcome to our practice. This agreement contains important information about our professional services. Your signature indicates your agreement to participate in your professional's practices.

1. **Outpatient Services**-This office is not an emergency clinic or an intensive program. We provide outpatient treatment only. When you call, doctors may be busy in sessions or out of the office on some days. Our office is closed on Fridays. For a true emergency, it is expected that patients will go to the closest emergency center, call 911 or call the Mobile Crisis Team at 602-222-9444. Doctors will return messages as soon as they are able.

2. **Doctor-Patient Communication**-Doctors encourage all appointments/contact to be in office or by phone/fax for brief contact. By emailing or texting doctors, you are automatically providing consent to use those means of communication. Dr. Mansoor does not use emailing. Dr. Picus strongly recommends face-to face appointments for all communications. You will be charged for communications outside sessions.

3. **24 Hour Cancellation Policy**-Patients will receive appointment reminder calls. THIS IS A COURTESY CALL ONLY. Responsibility to remember your appointment times is that of the patient/guardian. If you do not receive the call and/or fail to show, the patient/guardian will be responsible for payment of the missed appointment at the regular appointment rate. 24-hour business day notice is required for cancellation.

4. **Patient Records**-Patient records at this office are stored in electronic medical records that are HIPPA compliant. In case any doctor at this office should no longer be practicing, the remaining doctor will have access to stored records for the legally required 7 years length of time. You can call the office to receive records needed.

5. **Treatment Compliance**-Your doctors will provide clinically sound and ethical treatment. Compliance with all treatment recommendations will lead to utmost treatment efficacy.

6. **Absence from Treatment**-If your doctor has not received communication or follow up from you in approximately 3 months, you will receive a 2-week notice of discharge letter.

7. **NO Audio/Visual Recording**-To preserve privacy and the integrity of treatment/therapy relationship, this office does NOT permit recording of sessions of any kind. If Dr. Picus is court ordered to tape record an interview of a child, she may decline to tape.

8. **Confidentiality Limits**-In Dr. Picus' forensic cases, confidentiality may be limited depending on her role in your case. Releases will be required for collaborative parties. Dr. Picus may also have the responsibility to periodically inform the court of treatment status. Case information may be released through reports, records and court testimony, unless otherwise protected with a "Safe Haven" role.

9. **Duty to Report and Protect**- Dr. Picus and Dr. Mansoor are mandated reporters, and by state law, are required to report all cases of reported physical and sexual abuse or neglect of minors or the elderly.

10. **Danger to Self or Other Reporting-** If a patient is a risk to self or other Dr. Picus and Dr. Mansoor must take action to report and protect. Treatment will promote reaching for assistance to avoid risk and/or needing higher level of care.

11. **Fee for Service-** Dr. Mansoor and Dr. Picus do not accept insurance as third party payors. We do not take Medicare or Medicaid. All services are charged and due at time of service. We accept cash, check or credit cards.

I have read each guideline and consent to treatment as delineated above.

Patient Signature	Date
Mother/Guardian	Date
Father/Guardian	Date