Psychiatric & Psychological Affiliates of Scottsdale, **PLC**

14301 N. 87th Street, Suite 112•Scottsdale, AZ 85260
(P)480.609.0001 (F)480.607.2790

PATIENT IDENTIFICATION FORM

Name_____ **Today's Date:**_____
Last First Middle Initial

Current Mailing Address:_____ **Telephone Numbers:**
Street

(H): ( )_____
_____ (W): ( )_____
City State Zip Code (C): ( )_____

Pharmacy:_____ **Pharmacy Telephone:**_____

Reason for Referral: **Referred By:**

Sex:	**Marital Status:**	**Date of Birth:**_____
( )Male ( )Female	( )Separated ( )Widowed ( )Married ( )Single ( ) Divorced	**Age:** _____

IF MINOR CHILD AND PARENTS NOT LIVING TOGETHER:

Father's Name:_____ **Telephone Numbers:**

Address:_____ (H): _____
Street

(W): _____
_____
City State Zip Code (C):_____

Mother's Name:_____

Address:_____ (H):_____
Street

(W):_____
_____
City State Zip Code (C):_____

Consent for Treatment:

_____
Patient Date

_____
Mother/Guardian Date

_____
Father/Guadian Date

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OFFICE POLICIES AND CONSENT FOR TREATMENT FORM
JAMIE PICUS, PSY.D.

Patient Name:_____

***In order for you to be treated by Dr. Jamie Picus you must complete this form.**

FEES FOR FORENSIC/FAMILY/PSYCHOLOGY 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): $310	**Psychotherapy (45min): $175**
Follow-Up (15-20min): $65	**Psychotherapy (60min): $225**
Follow-Up (30min): $115	**Returned Check Fee: $25**

Testimony/Reports/Deposition Prep: $400/Hour
Collaborative Contact/Phone: $115 (30 min)
Expert Testimony/Deposition: $450/Hour
Additional 15 min blocks of time will be added to your appointment rate of $65.

DIVORCE/CUSTODY:

The parent 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. Jamie Picus 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. Please, charge any past due amount to my credit card below. (Please, check card type).

Credit Card #_____**Billing Zip** _____

( )Discover ( )Visa ( )MC ( )AmEx Expiration Date:_____**CVV Code**_____

I understand that Dr. Jamie Picus 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 **Date**

Mother/Guardian **Date**

Father/Guardian **Date**

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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. **Weekend Call For Dr. Mansoor's patients**- Dr. Mansoor has a psychiatrist "on-call" to cover weekend emergencies that are not an imminent risk matter. Our office number 480-609-0001 weekend message will provide the on-call number.

3. **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.

4. **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.

5. **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.

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

7. **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.

8. **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.

9. **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.

10. **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.

11. **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.

12. **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 Date

_____

Mother/Guardian Date

_____

Father/Guardian Date

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Patient Name:_____ DOB:_____

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 St, Ste, 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 St, Ste. 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 St. 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

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY (HIPAA) AGREEMENT

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
Mother/Guardian	Date
Father/Guardian	Date

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Patient Name:_____ DOB:_____

Verbal & Written Disclosure Authorization

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

Information will be shared with all authorized parties.
Names and relationships of who may be contacted are:

Parent/Guardian	Phone	Date
Parent/Guardian	Phone	Date
Physician	Phone	Date
School Counselor	Phone	Date
Psychologist/Therapist	Phone	Date
Psychiatrist	Phone	Date
Family/Significant Other	Phone	Date
Square Staff Billing/Credit Card Processing	Phone	Date
Other	Phone	Date
Other	Phone	Date

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
Mother/Guardian	Date
Father/Guardian	Date

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Patient Name:_____ DOB:_____

Forensic Verbal & Written Disclosure Authorization

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

Information will be shared with all authorized parties.

Names and relationships of who may be contacted are:

Judge	Phone	Date
Father's Attorney and Law firm Associates	Phone	Date
Mother's Attorney and Law Firm Associates	Phone	Date
Parent Coordinator	Phone	Date
Co-Parent Therapist	Phone	Date
Therapeutic Interventionist	Phone	Date
Child Legal Advocate	Phone	Date
Mother's Therapist	Phone	Date
Father's Therapist	Phone	Date
Other	Phone	Date

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
Mother/Guardian	Date
Father/Guardian	Date

Psychiatric & Psychological Affiliates of Scottsdale, PLC

Tel:480.609.0001 Fax :480.607.2790

CONSENT TO RECEIVE AND/OR RELEASE CONFIDENTIAL INFORMATION

Patient Name:_____ DOB:_____

I, _____, hereby authorize
( ) Saba Mansoor, MD ( ) Jamie Picus, PsyD
at 14301 N. 87th Street, Suite 112, Scottsdale, AZ 85260 to:

_____receive from: _____release to: _____exchange information with:

_____
Name/Facility

_____
Address

_____
City State Zip Code

(____)_____ (____)_____
Telephone Number Fax Number

the information below with regard to the services provided to me for the period of treatment from _____ to _____.

Purpose of Disclosure:_____

Information to be furnished:

____History & Physical	____Treatment & Discharge Summary	____Speech & Hearing Evaluation
____ Lab Results	____Psychological Testing	____Psychosocial Assessment
____Consultations	____Progress Notes	____EEG, MRI, CT Reports
____OT, PT Evaluations	____Other_____	____Other_____

This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This authorization is subject to revocation by me at any time except to the extend action has been taken in reliance herein. If not earlier revoked, this consent will last for the duration of the patient's treatment with provider(s) above.

_____ _____
Patient Date

_____ _____
Mother/Guardian Date

_____ _____
Father/Guardian Date