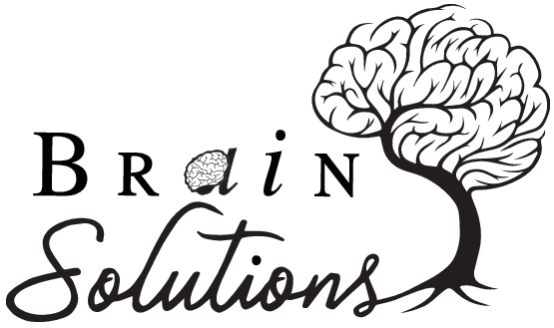

Bold Required

Patient Packet Checklist:

_____ _____ **Patient Demographic Form** (2 Pages) **/ Facesheet** (Facility)
Staff Initials Date Signed

_____ _____ **Patient History Form** (5 Pages)
Staff Initials Date Signed

_____ _____ **Consents for Evaluation & Treatment** (Facility)
Staff Initials Date Signed

_____ _____ **Credit Card Authorization Form**
Staff Initials Date Signed

_____ _____ **Financial Agreement** (Facility Non-AHCCCS)
Staff Initials Date Signed

_____ _____ Private Pay Agreement (If applicable)
Staff Initials Date Signed

_____ _____ MPOA (Medical Power of Attorney)/ Guardianship (Facility)
Staff Initials Date Signed

☐ Copies of Insurance card (Front & Back) (Facility Non-AHCCCS)

☐ Copy of Photo I.D.

Name:_____

DOB:_____ ID:_____

Patient Demographics Form

Name: _____ Today's Date: ____/____/____
Last First M.I

Refer to patient as: _____ DOB: ____/____/____ Age: _____

Home address: _____ Apt #: _____

City:_____ State:_____ Zip:_____ SSN: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Email: _____ Height: _____Weight: _____

How may we contact you with appointment reminders? ❑ Text ❑Email ❑Phone call

Employment Status: ❑Employed ❑Self-Employed ❑Homemaker ❑Stay-at-home Parent
❑Full-time Student ❑Part-time Student ❑Disabled ❑Unemployed ❑Retired

School or Employer:_____ Grade:_____

Ethnicity:_____ Religion:_____ Preferred Language:_____

Do you have a Medical Power of Attorney? **❑Yes ❑No Representative Name:** _____

Do you have a Mental Health Power of Attorney? **❑Yes ❑No Representative Name:** _____

Do you have a Legal Guardian/ Fiduciary? **❑Yes ❑No Representative Name:** _____

Paperwork of MPOA/ MHPOA/ Guardianship copies provided: **❑Yes ❑No**

Patient's Condition

Date of Current Illness Onset: _____ Date of Similar Illness: _____

Date of Current Hospitalization: From _____ To _____

Dates Unable to Work: From _____ To _____

Condition related to Employment? ❑Yes ❑No

Condition related to Auto Accident? ❑Yes ❑No If yes, State of accident: _____

Condition related to Other Accident? ❑Yes ❑No

Contacts

Emergency Contact Name: _____ Emergency Contact Number: _____

Relationship to Emergency Contact: _____ Contact Notes: _____

Contact	Name	Phone	Fax
Primary Care Physician			
Case Manager			
Pharmacy			

brain solutions

Name:_____

DOB:_____ **ID:**_____

Primary Insurance

Insurance Company Name: _____

Policy #: _____ Group #: _____ Copay/Deductable: _____

Carrier Address: _____

City:_____ State:_____ Zip:_____ Carrier Phone:_____

Patient Relationship to Insured:_____

Insured Name: _____
Last First M.I

Insured Address: _____ Apt #: _____

City:_____ State:_____ Zip:_____ Insured Phone: _____

Insured Date of Birth: ____/____/____ Insured Gender: _____

Insured Employer: _____

Secondary Insurance

Insurance Company Name: _____

Policy #: _____ Group #: _____ Copay/Deductable: _____

Carrier Address: _____

City:_____ State:_____ Zip:_____ Carrier Phone:_____

Patient Relationship to Insured:_____

Insured Name: _____
Last First M.I

Insured Address: _____ Apt #: _____

City:_____ State:_____ Zip:_____ Insured Phone: _____

Insured Date of Birth: ____/____/____ Insured Gender: _____

Insured Employer: _____

Additional Notes

_____

_____

_____

_____

_____

_____

Brain Solutions

Patient: _____

DOB: _____ **ID:** _____

Patient History Form

Name: _____ Date: ____/____/____ DOB: ____/____/____
Last First M.I

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ **SSN:** _____ Sex: ❑ F ❑ M

Height: _____ **Weight:** _____ How did you hear about Brain Solutions? _____

Transportation: If you use a service, Service Name: _____ Phone #: _____

Please check present symptoms:

- ❑ Sleep
- ❑ Appetite
- ❑ Depression
- ❑ Anxiety
- ❑ Panic: SOB
- ❑ Panic: Palpitations
- ❑ Panic: Dizziness
- ❑ Panic: Dread Paresthesia
- ❑ Irritability/Rage
- ❑ Racing Thoughts
- ❑ Concentration
- ❑ Motivation
- ❑ Interests
- ❑ Energy
- ❑ Guilty thoughts
- ❑ Hopelessness
- ❑ OCD
- ❑ Auditory Hallucinations
- ❑ Visual Hallucinations
- ❑ Delusions
- ❑ Self harm thoughts
- ❑ Homicidal thoughts
- ❑ Intent to harm
- ❑ Plan to harm
- ❑ Alcohol/Drug Use
- ❑ Other (please specify):

_____

_____

Previous Psychiatric Hospitalizations and Outpatient Treatments (when, where, and for what reason):

_____

_____

Previous suicide attempts or self-injurious behaviors (type, date):

_____

_____

Have you ever had psychotherapy? ❑Yes ❑No If yes, was it helpful? Please explain: _____

Please check if you have been diagnosed with any of these psychiatric or mental health disorders:

- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Social anxiety
- ❑ Stress Disorder
- ❑ Anorexia
- ❑ Bulimia
- ❑ Addiction of any kind
  - ❑ Gambling
  - ❑ Alcohol or drug
  - ❑ Sex
  - ❑ Computer gaming
  - ❑ Other: _____
- ❑ Schizophrenia
- ❑ Schizoaffective
- ❑ Psychosis
- ❑ Attention Deficit/Hyperactivity Disorder (ADHD)
- ❑ Learning Disorder
- ❑ Dementia
- ❑ Traumatic Brain Injury (TBI)
- ❑ Other (Please specify):

_____

Current Medication

Pharmacy Name: _____ Pharmacy Address: _____

Phone: _____ Fax: _____

Drug allergies? ❑Yes ❑No If yes, please specify: _____

Please list any medications you are now taking. Include dose, quantity, non-prescription medications, and vitamins/supplements:

_____

_____

_____

_____

Medication History

Please check the psychiatric medication that you have taken in the past:

- ❑ Abilify-aripiprazole
- ❑ Adderall-amphetamine
- ❑ Ambien-zolpidem
- ❑ Aricept-donepezil
- ❑ Atarix-hydroxyzine
- ❑ Ativan-lorazepam
- ❑ Buspar-Buspirone
- ❑ Celexa-citalopram
- ❑ Clozaril-clozapine
- ❑ Cogentin-benztropine
- ❑ Cymbalta-duloxetine
- ❑ Depakote-divalproex
- ❑ Desyrel-trazadone
- ❑ Effexor-venlafazine
- ❑ Elavil-amitriptyline
- ❑ Exelon Patch
- ❑ Geodon-ziprasidone
- ❑ Haldol-haloproraldol
- ❑ Invega-paliperidone
- ❑ Klonopin-clonazepam
- ❑ Lamictal-lamotrigine
- ❑ Latuda-lurasidone
- ❑ Lexapro-escitalopran
- ❑ Lithium-eskalith
- ❑ Lunesta-eszopiclone
- ❑ Luvox-fluvoxamine
- ❑ Namenda-memantine
- ❑ Neurontra- gabapentin
- ❑ Pamelor-nortriptyline
- ❑ Prozac-flouxetine
- ❑ Paxzil-Parozetine
- ❑ Remeron-mirtazapine
- ❑ Ritalin-methylphenidate
- ❑ Rozerem-reamelteon
- ❑ Risperdal-risperidone
- ❑ Seroquel-quetiapine
- ❑ Sonata-zaleplon
- ❑ Tegretol- carbamazepine
- ❑ Trazodone
- ❑ Trilafon-perphenazine
- ❑ Valium-diazepam
- ❑ Viibryd-vilazodone
- ❑ Vyvanse-lisdexamfetamine
- ❑ Wellbutrin-buproprion
- ❑ Xanax-alprazolam
- ❑ Zoloft-sertraline
- ❑ Zyprexa-olanzapine
- ❑ Other:_____

Past Medical History

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type):

  _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach/peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Arthritis
- ❑ Head Injury
- ❑ Other Seizures

Women's Reproductive History

Do you have regular periods? ❑Yes ❑No Age of first period: _____

Have you reached menopause? ❑Yes ❑No If yes, at what age? _____ Number of:

Pregnancies	Miscarriages	Abortions

Personal History

Were there problems with your birth? ❑Yes ❑No If yes, please specify: _____

Where were you born and raised? _____

What is your highest education? ❑High School ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑Never married ❑Married ❑Divorced ❑Separated ❑Widowed ❑Partnered/significant other

Are you working? ❑Yes ❑No

If yes, what is your current occupation? _____ Hours/week: _____

If no, what is your past occupation and reason for leaving? _____

Religion/Spirituality: _____

Do you receive disability or SSI? ❑Yes ❑No If yes, for what disability and how long? _____

Have you ever had legal problems? ❑Yes ❑No If yes, please specify: _____

Have you ever been arrested for a DUI? ❑Yes ❑No

Past Personal Treatment History

Check all that apply (please specify age[s]):

- ❑ Outpatient: _____
- ❑ Inpatient: _____
- ❑ IOP (Intensive Outpatient): _____
- ❑ Substance Abuse 12-step program: _____
- ❑ Stopped on own: _____
- ❑ Other (specify): _____

Personal substances used/abused (complete all that apply):

	First Use Age	Frequency	Amount	Current Use	Last Use Age
Tobacco/cigarettes/nicotine					
Amphetamines/speed					
Cannabis/MJ/THC					
Heroin/opiates/pain meds					
Cocaine					
Crack cocaine					
Alcohol					
Inhalants (e.g. glue, gas, etc)					
Other: _____					

Consequences of substance abuse (check all that apply):

- ❑ Hangovers
- ❑ Seizures
- ❑ Blackouts
- ❑ Overdose
- ❑ Withdrawal symptoms
- ❑ Medical conditions
- ❑ Tolerance changes
- ❑ Loss of control amount used
- ❑ Sleep disturbance
- ❑ Assaults
- ❑ Suicidal impulse
- ❑ Relationship conflicts
- ❑ Binges
- ❑ Job loss
- ❑ Arrests
- ❑ Other:_____

Family History

	Age(s)	Medical	Psychiatric	Substance abuse	Age and Cause of death
Grandfather *Maternal/Paternal					
Grandmother *Maternal/Paternal					
Mother					
Father					
Uncle					
Aunt					
Sibling(s)					
Children					

*Please circle one

Systems Review

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much:
- ❑ Recent weight loss; how much:
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

THROAT
- ❑ Frequent sore throat
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Pain in jaw

BLOOD
- ❑ Anemia
- ❑ Clots

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting/loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Swollen legs or feet
- ❑ Cough

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling (where):

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

WOMAN ONLY
- ❑ Abnormal pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide/attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Guilty thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Racing thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS

_____

Please list any additional concerns or information helpful to your treatment:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Health Questionnaire (PHQ-9)

Name: _____

Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Please Circle to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Brain Solutions

Patient:_____

DOB:_____ ID:_____

Consent for Evaluation and Treatment

Patient or patient's legal representative agree to the following terms for encounters with Brain Solutions PLLC (BS):

1. **Treatment**: The patient consents to the treatment and services provided by Brain Solutions which may include but are not limited to: psychotherapy, psychiatric services, evaluating patients before prescribing medications, refilling existing prescriptions, regular monitoring of medication use, behavioral healthcare, and any necessary periodic laboratory tests.
2. **Release of Information**: The patient acknowledges and agrees that any health and/or financial information (including information regarding alcohol or drug abuse, HIV related or to other communicable disease related information) may be released to the following:
    a. Healthcare providers or their agents who are providing or have provided healthcare to the patient; any individual or entity responsible for payment of BS's charges; to health care providers or organizations.
    b. All BS staff members, contractors, business associates, service locations, facilities and services and associated staff, and contractors.
    c. Individuals and entities as specified by law, ethical standards, and per insurance billing requirements.
    d. Patients covered under TXIX/TXXI Healthcare benefits waive the right to confidential disclosure with their Primary Care Physician.
3. **Contraband**: Drugs, alcohol, weapons, and other articles specified as contraband by BS may not be brought onto BS Premises. Any illegal substance will be confiscated and turned over to law enforcement authorities.
4. **Dismissal From Provider Services or BS**: Patient may be dismissed from provider care or BS for:
    1. Excessive no-shows/late arrivals, 2. Inappropriate or disruptive behavior, 3. Failure to follow treatment recommendations, 4. Medication dishonesty, 5. Failure to meet financial obligations, 6. Providing false or inadequate information, 7. Failing to authorize the release of records to BS or, 8. Being a difficult patient.
5. **Teaching Program**: BS participates in training programs for therapists and health care personnel. Some patient services may be provided by persons in training, under the supervision and instruction of therapists or other BS providers. These persons in training may also observe care given to the patient by therapists and BS providers and/or contractors. Patient will be notified if treatment is being provided by an unlicensed provider who is directly supervised by a licensed provider. With consent, any observation (e.g. video-taped or audio-taped) by a provider supervisor will be used strictly for educational purposes. Any questions regarding supervision will go to the Clinical Director, Jonathan C. Mackey, LCSW.
6. **Communication**: I understand that BS may: ___Call or ___Text at this number:_____

    Or email:_____

    I authorize the following individuals to inquire and receive verbal information regarding my care.

    _____
7. **Terms of the Agreement**: This agreement shall remain in effect as long as I am seeking services from BS. I acknowledge that I have read, understood and agree to the terms and conditions as outlined in the patient information packet. I may be asked to sign a new agreement every year. This release shall continue for so long as the medical/behavioral health and/or financial records are needed for payment, treatment, or healthcare operations.

I acknowledge receipt of the Notice of Privacy Practices and the Notice of Health Information Practices, this includes information regarding the participation of BS in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy. I am the patient or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement. This includes my email and phone communication preferences.

_____ _____

Patient/Authorized Representative Relationship to Patient

_____ _____

Witness (Printed Name/ Signature) Date/Time

Brain Solutions

Patient:_____

DOB:_____ ID:_____

Financial Agreement

I agree that in return for the services provided to me or the patient (if a different person - hereafter the word 'patient' applies to both) by Brain Solutions PLLC or other affiliates, I will pay the account of the patient and/or make financial arrangements satisfactory to Brain Solutions PLLC. Unless the patient's bill is paid by applicable insurance, government programs or other sources, I agree to pay Brain Solutions PLLC's usual and customary charges. If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses in addition to the amount due and owing on the bill for medical and behavioral health services rendered to the patient if I am ultimately found to be liable for the bill. I understand and agree that a delinquent account will be subject to interest at the legal rate.

I understand and agree that my insurance and/or the patient's' insurance, if any, will be billed for services rendered to the patient. Payment from the insurer will be sought by Brain Solutions PLLC before I am required to make payment (with the exception of some percentage of co-insurance or co-payment, which I must pay) I understand and agree that I am responsible for knowing my coverage and being transparent with any coverage changes. I further understand and agree that as part of the normal business communication with Brain Solutions PLLC, with regard to this matter, Brain Solutions PLLC staff or representatives may contact me through any of the following methods: letter, email, telephone, text/voice message, or any other available technologies used by businesses for such communications.

If the patient is entitled to any benefits whatsoever, under any policy of health, liability insurance, or from any other party liable to the patient, these benefits are hereby assigned to Brain Solutions PLLC and/or to the providers rendering services for application toward the patient's bill. I authorize the release of any medical and/or account information necessary to process claims/direct payment of benefits from my insurance company and collect payment for services rendered, including any applicable service charges and applicable costs of collections. It is understood and agreed, however, that the patient and I may be contacted using an auto-dialer during collection proceedings.

If you need to cancel or reschedule an appointment, please provide us with at least a 24-hour notice. **If you miss a scheduled appointment without contacting us for cancellation, or cancel with less than a 24-hour notice, our policy is to assess a $100.00* fee payable to Brain Solutions** [unless you and your provider both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the full fee amount as described above. Brain Solutions reserves the right to suspend services until the fee is paid. **Excessive appointment no shows and frequent late arrivals is grounds for discharge from our services.** This includes cancellations without the required 24-hour notice. This cancellation policy is standard in most medical and behavioral health practices and will be strictly enforced.

***Patients covered under TXIX/TXXI healthcare benefits are exempt from paying a fee.**

In the event that the patient has a payment on an active account, whether through cash, check, credit card or other means, and there remain additional funds available after that account is satisfied (e.g. an overpayment), Brain Solutions PLLC is authorized to apply the overpayment to any other account owed by the patient that remains unpaid. Brain Solutions reserves the right to charge a nominal processing fee for all credit card transactions.

I have read, understand, and agree to adhere to Brain Solutions PLLC's Financial Agreement as stated above.

_____ _____

Patient/Authorized Representative Relationship to Patient

_____ _____

Witness Date/Time

Patient:_____

DOB:_____ ID:_____

Private Pay Agreement

I agree that in return for the services provided to me or the patient (if a different person - hereafter the word 'patient' applies to both) by Brain Solutions PLLC or other affiliates, I will pay the account of the patient and/or make financial arrangements satisfactory to Brain Solutions PLLC. Payment for services is due in full at the time services are rendered. If the service is not paid in full at the time of the appointment, the session is subject to cancellation per the discretion of Brain Solutions PLLC. Payment amounts vary and are dependent on the type of services provided. Brain Solution's staff will provide you with an estimate at the time of service.
If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses in addition to the amount due and owing on the bill for medical and behavioral health services rendered to the patient if I am ultimately found to be liable for the bill. I understand and agree that a delinquent account will be subject to interest at the legal rate.

I understand and agree that my insurance and/or the patient's' insurance, if any, will **NOT** be billed for services rendered to the patient. I further understand and agree that as part of the normal business communication with Brain Solutions PLLC, with regard to this matter, Brain Solutions PLLC staff or representatives may contact me through any of the following methods: letter, email, telephone, text/voice message, or any other available technologies used by businesses for such communications. It is understood and agreed, however, that the patient and I may be contacted using an auto-dialer during collection proceedings.

If you need to cancel or reschedule an appointment, please provide us with at least a 24-hour notice. **If you miss a scheduled appointment without contacting us for cancellation, or cancel with less than a 24-hour notice, our policy is to assess a $100.00 fee payable to Brain Solutions** [unless you and your provider both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the full fee amount as described above. Brain Solutions reserves the right to suspend services until the fee is paid. **Excessive appointment no shows and frequent late arrivals is grounds for discharge from our services.** This includes cancellations without the required 24-hour notice. This cancellation policy is standard in most medical and behavioral health practices and will be strictly enforced.

In the event that the patient has a payment on an active account, whether through cash, check, credit card or other means, and there remain additional funds available after that account is satisfied (e.g. an overpayment), Brain Solutions PLLC is authorized to apply the overpayment to any other account owed by the patient that remains unpaid. Brain Solutions reserves the right to charge a nominal processing fee for all credit card transactions.

I have read, understand, and agree to adhere to Brain Solutions PLLC's Private Pay Agreement as stated above.

_____ _____

Patient/Authorized Representative Relationship to Patient

_____ _____

Witness Date/Time

Brain Solutions

Patient:_____

DOB:_____ ID:_____

Credit Card Pre-Authorization Form

Due to the increasing costs being placed on patients by insurance companies, for non-covered services by the plans, we require payment information on file so we can continue to provide quality healthcare at reasonable rates.

By signing, I authorize Brain Solutions PLLC to charge my credit card for agreed upon services and understand that my information will be saved to file for future transactions on my account. I also agree to notify Brain Solutions PLLC of any card renewals or account changes.

Cardholder Name (exactly as on the card):

_____

Cardholder ZIP Code:_____

Card Number _____ Exp. Date ____/____ CVV# _____

❑Visa ❑MasterCard ❑Discover ❑AMEX ❑HSA ❑Other:_____

SSN: _____

Signature: _____ Date:_____

Witness: _____

*This form is REQUIRED by all patients prior to receiving services with Brain Solutions.

***Patients covered under TXIX/TXXI healthcare benefits are exempt from completing the Credit Card Pre-Authorization Form.**

Brain Solutions

Patient: _____

DOB: _____ ID: _____

Authorization for Release of Medical Information (Behavioral Health)

Organization Who Is Releasing Information	
Facility:	
Address:	
City, State:	Zip Code:
Fax:	Phone:

To Whom Information Will Be Provided	
Entity/Individual:	
Address:	
City, State:	Zip Code:
Fax:	Phone:

Patient Information:	Patient Name: _____ Address: _____ _____	Date of Birth: _____ Phone #: _____
Dates Requested:	From: _____	To: _____

*** There may be a FEE associated with your Request for Records**

Records Being Requested:

Health Center/ Clinic Records

- ❑ **All Pertinent Records** (including those listed below)
- ❑ Office Visits/ Progress Note(s)
- ❑ Discharge Summary
- ❑ Immunization Record
- ❑ Laboratory Report
- ❑ Medication List
- ❑ EKG Report
- ❑ Imaging/X-ray Report
- ❑ Imaging/X-ray CD/Film
- _____
- ❑ Consultation
- ❑ Behavioral/ Psychiatric Office visit
- ❑ Official Medical Record
- ❑ Other _____

Hospital Records

- ❑ **All Pertinent Records** (including those listed below)
- ❑ Allergies
- ❑ Consultation
- ❑ Discharge Summary
- ❑ ER Report
- ❑ EKG Report
- ❑ History & Physical
- ❑ Laboratory
- ❑ Medication List
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Problem List
- ❑ X-ray Report
- ❑ Other _____

Other Records:

❑ Billing Record ❑ Genetic Testing ❑ Photos

Further explanation of request: _____

Delivery of Records:

Paper Requests: ❑ Mail ❑ Pick-up ❑ Courier ❑ Fax

Electronic Requests: ❑ E-mail ❑ CD ❑ I Do Not want my electronic record Encrypted

Email Address for Record Delivery																									

(Complete only if requesting records via Email)

Unencrypted data sent by email can be intercepted by Unauthorized Parties

Purpose:

❑ Self ❑ Continuing Care ❑ Other (please specify): _____

Brain Solutions

Patient:_____

DOB:_____ ID:_____

Authorization for Release of Medical Information (Behavioral Health)

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/ Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing: my signature authorized release of any such information

I may refuse to sign this authorization form. I understand that Brain Solutions PLLC will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Brain Solutions PLLC Notice of Privacy Practices explains the process for revocation, which includes a request in writing.

I understand that I have a right to receive a copy of this authorization.

This Authorization pertains to the dates specified on this Authorization. Unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand that if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I release Brain Solutions PLLC, its employees and agents, staff members, contractors and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient _____ Date: _____

Signature of Legal Representative _____ Date: _____

Relationship to Patient _____ Date: _____

For Office Use Only		
Employee printed name who completed/reviewed form with patient:		
Verbal Release or Viewed EMR (document information/ person authorized):		
Date Received:	Date Completed:	Processing Initials:
POA Verified:	ID/License Verified:	
Comments for CROI:		

Records picked up by: _____ Date: _____

If you have questions regarding this request for medical records, please contact our BH Coordinators at:

Brain Solutions PLLC, 1835 W. Chandler Blvd, Suite 100, Chandler, AZ 85224
Phone: (480) 779-9050 Ext 1 Fax: (480) 717-4025 Email: Admin@brainsolutionsAZ.com

Patient Information

Welcome to Brain Solutions! This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law providing privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

Patient/Provider Relationship

Behavioral health treatment involves a relationship between people that works due to clearly defined rights and responsibilities held by each person. There are legal limitations to those rights that you should be aware of. You and your provider with Brain Solutions will establish a professional relationship existing exclusively to provide therapeutic treatment.

Prescription Refills

All providers are required to evaluate a patient before prescribing any new medications or refilling existing prescriptions; taking into account patient medical history, other medications, and allergies. **The office will refill prescriptions during your scheduled appointments. You may contact your pharmacy regarding prescription refills. No prescriptions will be authorized after hours or on weekends. All providers reserve the right to decline a prescription refill request when an appointment is necessary for medication evaluation and management. Plan ahead at least 10 business days for your refill request.** If the medication is a controlled substance, the law requires a written prescription. You will need to set up a follow-up medication refill appointment.

Appointments

Appointments will ordinarily be 50 minutes in duration for psychotherapy and 15 minutes for psychiatric evaluation and management, although some sessions may be more or less time as needed. The time scheduled for your appointment is assigned to you and you alone. You are responsible for arriving 15 minutes prior to your appointment time. If you are less than 15 minutes late, it is up to the discretion of the provider if you are to be seen.

Cancellation/No Show Appointment Policy

If you need to cancel or reschedule an appointment, please provide us with at least a 24-hour notice. **If you miss a scheduled appointment without contacting us for cancellation, or cancel with less than a 24-hour notice, our policy is to assess a $100.00* fee payable to Brain Solutions** [unless you and your provider both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the full fee amount as described above. Brain Solutions reserves the right to suspend services until the fee is paid. **Excessive appointment no shows and frequent late arrivals is grounds for discharge from our services.** This includes cancellations without the required 24-hour notice. This cancellation policy is standard in most medical and behavioral health practices and will be strictly enforced.

*Patients covered under TXIX/TXXI healthcare benefits are exempt from paying a fee.

Professional Records

The laws and standards of our profession require that we keep treatment records. Your records are maintained in a secure online system that meets or exceeds the HIPAA Security Rule. Although psychotherapy often includes discussion of private information,

normally records are kept very brief and note the time and location of the visit, what was done in session, goal progress, and diagnoses.

Except in unusual circumstances, you have the right to request a copy of your records. In certain situations where there is compelling evidence that access may cause harm to you, Brain Solutions recommends that you review your records with a provider. We recommend that your review them in the presence of your provider. You have the right to request that a copy of your file be made available to any other health care provider through your written request for Release of Information. Patients will be charged a $25.00 fee for records.

In the event of Brain Solutions terminating the practice, active patients will be notified and may locate their provider by calling a number provided to them via letter, email phone call, or direct verbal communication. For reasons of personal privacy Brain Solutions will only provide direct access to current or recent patients providing them with available contact numbers. Brain Solutions will maintain a contact number for a period of three to six months, depending on circumstances at the time of closing of the practice. Brain Solutions will dispose of unclaimed records after the current legal and/or legally specified time requirements. In the event that circumstances require, Brain Solutions will forward record access and responsibility to another professional who will respond to record requests in accordance with legal and professional guidelines.

Confidentiality

You have the right to the confidentiality of your treatment, with a few specific exceptions described here. Brain Solutions will not disclose any information you have shared with Brain Solutions without your prior written permission outlined in the Consent for Evaluation and Treatment Form. You will be notified if treatment is being provided by an unlicensed provider who is directly supervised by a licensed provider. You may request anyone of your choosing to attend a therapy session with you.

You are protected under the provision of HIPAA, insuring the confidentiality of all electronic transmission of information about you. It will be done with special safeguards to insure confidentiality and security.

If you elect to communicate with your provider by email during your work together, please be aware that email is not completely confidential and there are inherent risks to the security of this information. Any email Brain Solutions receives from you, and any responses that we send to you, may be copied and kept in your treatment record.

There are a limited number of situations in which Brain Solutions is required by law and ethical standard to disclose information about you without your authorization. Please read the Brain Solutions Notice of Privacy Practices for more information.

Providers will occasionally consult with other professionals about a case, taking every effort to maintain patient confidentiality. The consultant is legally bound to keep any information confidential. Providers will inform patients of consultations if it pertains to the treatment process.

Contact information

Brain Solutions PLLC
1835 W. Chandler Blvd, Suite 100
Chandler, AZ 85224
Phone: (480) 779-9050
Fax: (480) 717-4025
Website: www.brainsolutionsAZ.com

If, for any reason, you are not able to reach your provider and you feel that you cannot wait for a return call and/or feel unable to keep yourself safe, CALL 9-1-1 or go to the nearest emergency room and ask for the social worker/psychologist/psychiatric provider on call. Brain Solutions does not provide crisis services. If you are experiencing a crisis and need to get assistance with behavioral health services, in addition to the options above, you may contact the National Suicide Prevention Lifeline at 1-800-273-8255, Maricopa County Crisis line 1-800-631-1314 or 602-222-9444, or 1-866-495-6735 if outside of Maricopa County.

Notice of Privacy Practices for Brain Solutions

This notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information. Please review carefully. Effective date September 25, 2017.

Introduction

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices.

How will we use and disclose information about you?

Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant with authorization.

Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you such as: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

Health Care Operations: We may use or disclose your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law: Under the law: we must disclose your PHI to you upon your request, make disclosures to the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, and disclose your PHI to a state or local agency authorized to receive reports of abuse or neglect of a child or vulnerable adult. Federal, state, or local laws do not require patient consent to disclose information which is required to be reported.

Judicial Proceedings: We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients: We may disclose PHI regarding deceased patients as mandated by state and federal laws, or to a family member or friend that was involved in your care or payment for care prior to death, based on prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as possible after the resolution of the emergency.

Family Involvement in Care: We may disclose information to close family members or friends directly involved in your treatment based on your written consent, verbal consent, or as necessary to prevent serious harm.

Health Oversight: If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Coroners, Medical Examiners: Brain Solutions may disclose medical information concerning deceased patients to coroners or medical examiners to assist them in carrying out their duties

Law Enforcement: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written

consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions: We may review requests from U.S. military command authorities and disclose your PHI based on your written consent if you have served as a member of the armed forces. Authorities include the department of Veterans Affairs, authorized officials for national security and intelligence reasons, the Department of State for medical suitability determinations, mandatory disclosure laws, and the need to prevent serious harm.

Information with Additional Protection: Certain types of medical information may have additional protection under state or federal law. For instance, medical information about alcohol abuse treatment, psychotherapy notes, genetic testing, or court ordered mental health evaluations.

Health Information Exchange (HIE): We are a participating provider in a non-profit, non-governmental health information exchange (HIE) called Health Current. Healthcare providers, and health plans better coordinate your care by securely sharing your health information. You have certain rights regarding HIE under state and federal law. Information is shared for treatment, care coordination, care or case management, and transition of care planning and population health services. Federal and state laws, such as HIPAA, protect the confidentiality of your health information. You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current: 1. You may "opt out" of having your information available for sharing through Health Current.

Other Uses and Disclosures: Other uses and disclosures not described in this Notice will be made only with your written authorization such as sale of medical information. You may revoke such an authorization by sending us a written request.

What are your rights?

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Jonathan C. Mackey at Brain Solutions PLLC, 1835 W Chandler Blvd, Suite 100, Chandler, AZ 85224.

Right of Access to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a healthcare item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication: You have the right to request that we communicate with you about health matters in a way you feel is more confidential. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request.

Breach Notification: If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice: You have the right to a copy of this notice. You may obtain a copy of the notice from our web site at www.brainsolutionscenter.com or obtain a paper copy at the office.

Changes to this notice

We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, or providing a copy upon request.

Do you have any concerns, complaints, or questions?

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Jonathan C. Mackey at Brain Solutions PLLC, 1835 W Chandler Blvd, Suite 100, Chandler, AZ 85224 by calling (480) 779-9050 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.