ADHD Clinic of Arizona

Tempe Clinic
8675 S. Priest Dr. Ste.102
Tempe, AZ 85284
480-739-0007 Clinic

Gilbert Clinic
3303 E. Baseline Rd. Ste. 114 Bld 6
Gilbert, AZ 85234
480-553-8517 Clinic

Office Policies and Procedure

We appreciate the confidence you have shown by choosing our office to provide medical care to you and your family. We make every effort to give you the best possible care. In order to achieve this, we ask for your assistance in the following clinic policies.

APPOINTMENTS

Appointments are required to address any/all issues and concerns. Regular office hours are Monday through Friday from 8:00am–5:00pm with lunch from 12pm-1:00pm We reserve some appointment times for same day "sick" visits every day. We work hard to accommodate requests for same day appointments but are not always able to do so. New patients must arrive 30 minutes prior to their appointment time. If you are an established patient, please arrive 10 minutes prior to your appointment time. If you arrive late, we may need to reschedule your appointment.

If you are unable to keep your scheduled appointment, please call our office 24hrs hours ahead to cancel so that your appointment time can be made available to other patients. It is our policy that **if you do not show for 3 appointments you will be notified by mail that you will be discharged from the practice.** ADHD Clinic of Arizona reserves the right to bill $50 for No-Show appointments.

TEST RESULTS

If any test is not within normal range our medical assistants will call you to make a follow-up appointment to go over your results. **You will be subject to co-pay if your plan requires you to pay co-pay for your visits.** If results are within normal limits our medical assistants will call you to go over results. If you should have any questions after you receive your results **a follow-up appointment is required.**

MEDICATION REFILLS

We require 72 hours notification for all refill requests. Please do not allow yourself to run out of medication. Your provider requires advance notice, as he/she needs to evaluate your medical records. **Narcotic medications will NOT be refilled without an office visit. Medication refills will not be refilled after hours.**

REFERRALS

All referrals require an office visit. When your provider wants you to be referred to a specialist, it will take up to **10 business days for completion**. If it is an **urgent referral**, it will be completed within **48 hours**. You will receive all the information you need by mail or phone so that you are then able to call and schedule your appointment. If your specialist requires additional visits, it is your responsibility to verify that the specialist is contracted with your insurance prior to your visit.

MEDICAL RECORDS

For all medical record requests, a release form will be provided and must be signed by the patient. Please allow 15 business days to process your request. Your records may be faxed to another physician's office OR made available for you to pick up in our office, please note: If you are picking up records from our office there is a minimum charge of $15.00 for up to 30 pages.

PHYSICIAN PHONE CONSULT

Our providers do not usually consult patients over the phone. If this becomes a necessity which is not a medical emergency, we reserve the right to charge you a consultation fee **(most insurance plans do not cover phone consultations, so therefore this charge will be your responsibility).**

INSURANCE

It is the patient's responsibility to understand their insurance plan benefits. We will try to assist you, when possible with what is and is not covered. **The patient is responsible for services/items that the insurance does not cover.**

PAYMENTS

The patient is responsible for payment of each office visit. If you have insurance, our billing department will file the claim with them as a courtesy. Please have your insurance card with you at each visit. **Co-payments and payments are always required on the day of service.** If you do not bring your payment with you, we reserve the right to reschedule your appointment. **Patients without insurance will need to pay for their service on the day it is rendered.** Please pay with cash, credit or debit card. We do not accept checks. **A 33% fee will be added to accounts that are sent over to collections.**

AFTER-HOURS EMERGENCIES

If you have a true medical emergency, please call 911 or go to the nearest emergency room to receive medical assistance immediately. **I have reviewed the policies listed above in their entirety and consent to be treated. I have reviewed and received an Advanced Care Directive and a copy of my patient rights.**

Signature	Print Name	Date

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NO SHOW APPOINTMENT POLICY

ADHD Clinic of Arizona reserves the right to charge a $50 fee to the patient for all No-Show Appointments, where the patient does not call or email the clinic at least 24 hours prior to his/her appointment (or a minor's appointment) to cancel a scheduled appointment.

If you are unable to keep your scheduled appointment, please call or email our office at least 24hrs hours ahead to cancel so that your appointment time can be made available to other patients. It is also our policy that **i**f you do not show for 3 scheduled appointments you will be notified by mail that you have been discharged from the practice.

Signature of Patient/ Guardian/ Parent	Relationship	Date

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Patient Information/Informacion del Paciente

Date/Fecha: _____ Email: _____

Name/Nombre: _____ SSN./Numero de Seguro Social: _____

Age/Edad: _____ Sex/Sexo: M/F Marital Status/Estado Civil: _____ DOB/Fecha de Nacimiento:_____

Home Phone/Numero de Casa:_____ Cell Phone/ Numero de Cellular:_____

Address/Direccion: _____Apartment/Apartamento: _____

City/Ciudad: _____State/Estado: _____Zip/Codigo Postal: _____

Occupation/Ocupacion: _____ Employer/ Empleador: _____

If need arises, the doctor/receptionist may leave a message on my (circle one that apply)
Si necesitan, el doctor/recepcionista puede dejar mensaje en mi (marquee todos los que aplican)

Home phone/Numero de Casa Cell Phone/Numero de Cellular Family Name/Nombre de Familiar: _____

Spouse or Emergency Contact Information (or Parent/Guardian if Patient is Child)

Name/Nombre: _____ SSN/ Numero del Seguro Social: _____

Age/Edad: _____ Sex/Sexo: M/F Marital Status/Estado Civil: _____ DOB/Fecha de Nacimiento: _____

Home Phone/Numero de Casa:_____ Cell Phone/ Numero de Cellular:_____

Address/Direccion: _____Apartment/Apartamento: _____

City/Ciudad: _____State/Estado: _____Zip/Codigo Postal: _____

Occupation/Ocupacion: _____ Employer/ Empleador: _____

Medical Insurance Information/ Informacion del Seguro Medico

Primary Insurance Company Name/ Nombre del Seguro Medico Primario:

_____

Member ID #/ # de ID de Miembro: _____ Group Number/ Numero de Grupo: _____

Subscriber Name/ Nombre del Encargado: _____DOB/ Fecha De Nacimiento: _____

Secondary Insurance Company Name/ Nombre del Seguro Medico Primario:

_____

Member ID #/ # de ID de Miembro: _____ Group Number/ Numero de Grupo: _____

Subscriber Name/ Nombre del Encargado: _____DOB/ Fecha De Nacimiento: _____

Please make sure you update your information with us if there are any changes. Thank you.
Por favor de informarnos si ay algun cambio en su informacion. Gracias.

_____ _____ _____
Signature of Patient/ Guardian/ Parent Relationship/ Relacion Date

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, MI.):	**DOB:**
Marital Status: □Single □Partnered □Married □Separated □Divorced □Widowed	
Previous or referring Doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio		
Immunizations and Dates:	□ **Tetanus**	□ **Pheumonia**
	□ **Hepatitis**	□ **Chickenpox**
	□ **Influenza**	□ **MMR (Measles, Mumps, Rubella)**
List any medical problems that other doctors have diagnosed:		

Surgeries		
Year	**Reason**	**Hospital**

Other Hospitalizations		
Year	**Reason**	**Hospital**

Have you ever had a blood transfusion?	□ **Yes** □ **No**

List your prescribed drugs and over the counter medication, such as vitamins and inhalers		
Name of the Drug	**Strength**	**Frequency Taken**

Allergies to Medications	
Name of the Drug	**Reaction you had**

HEALTH INFORMATION AND PERSONAL SAFETY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record				
Exercise	□ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	□ Occasional vigorous exercise (i.e., work or recreation, less than 4/week for 30 min.)			
	□ Regular vigorous exercise (i.e., work or recreation 4/week for 30 min.)			
Diet	Are you dieting?		□ Yes	□ No
Caffeine	□ None	□ Coffee	□ Tea	□ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		□ Yes	□ No
	How many drinks per week?			
Tobacco	Do you use tobacco?		□ Yes	□ No
Drugs	Do you currently use recreational or street drugs?		□ Yes	□ No
Sex	Are you sexually active?		□ Yes	□ No
	If yes are you trying for a pregnancy?		□ Yes	□ No
	Contraception:			
	Any discomfort with intercourse?		□ Yes	□ No
	Would you like to speak with your provider about your risk of HIV/AIDS?		□ Yes	□ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	□ **M** □ **F**	
Mother				□ **M** □ **F**	
Sibling	□ **M** □ **F**			□ **M** □ **F**	
	□ **M** □ **F**			□ **M** □ **F**	
	□ **M** □ **F**		**Grandmother** ***Maternal***		
	□ **M** □ **F**		**Grandfather** ***Maternal***		
	□ **M** □ **F**		**Grandmother** ***Paternal***		
	□ **M** □ **F**		**Grandfather** ***Paternal***		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain

□ Skin	□ Chest/Heart	□ Recent changes in:
□ Head/Neck	□ Back	□ Weight
□ Ears	□ Intestinal	□ Energy level
□ Nose	□ Bladder	□ Ability to sleep
□ Throat	□ Bowel	□ Other pain/discomfort:
□ Lungs	□ Circulation	

HEALTH INFORMATION AND PERSONAL SAFETY

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every ___days		
Heavy periods, irregularity, spotting, pain, or discharge?	□Yes	□No
Number of pregnancies ____ Number of live births	□Yes	□No
Are you pregnant or breastfeeding?	□Yes	□No
Have you had a D&C, hysterectomy, or Cesarean?	□Yes	□No
Any urinary tract, bladder, or kidney infections within the last year?	□Yes	□No
Any blood in your urine?	□Yes	□No
Any problems with control of urination?	□Yes	□No
Any hot flashes or sweating at night?	□Yes	□No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?	□Yes	□No
Experienced any recent breast tenderness, lumps, or nipple discharge?	□Yes	□No
Date of last pap and rectal exam?_____ Date of last Mammogram? _____ Date of last DEXA Scan ? _____ Date of last Colonoscopy? _____		

MEN ONLY		
Do you usually get up to urinate during th night?	□Yes	□No
If yes number of times _____		
Do you feel pain or burning with urination?	□Yes	□No
Any blood in urine?	□Yes	□No
Do you feel burning discharge from penis?	□Yes	□No
Has the force of your urination decreased?	□Yes	□No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	□Yes	□No
Do you have any problems emptying your bladder completely?	□Yes	□No
Any difficulty with erection or ejaculation?	□Yes	□No
Any testicle pain or swelling?	□Yes	□No
Date of last prostate and rectal exam? _____ Date of last DEXA Scan? _____ Date of last Colonoscopy? _____		

MENTAL HEALTH		
Is stress a major problem for you?	□Yes	□No
Do you panic when stressed?	□Yes	□No

Do you have problems with eating or your appetite?	□Yes	□No
Do you cry frequently?	□Yes	□No
Have you ever seriously thought about hurting yourself?	□Yes	□No
Do you have trouble sleeping?	□Yes	□No
Have you ever been to a counselor?	□Yes	□No
Do you feel depressed?	□Yes	□No
Have you ever attempted suicide?	□Yes	□No

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

You may refuse to sign this Acknowledgement

I, _____ have received a copy of this Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: ___/___/___

For Office Use Only

We attempted to obtain written acknowledgement of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please Specify) _____

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner (Check all that apply)

Home Telephone (___) ____-_____
Okay to leave message with instructions
Okay to leave message with call-back number only

Written Communication
Okay to mail to home address
Okay to mail to work/office address
Okay to fax to _____

Work Telephone (___) ____-_____
Okay to leave message with instructions
Okay to leave message with call-back number only

SSN _____

_____ _____
Patient Signature Date

_____ _____
Patient Name (Print) Date of Birth

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Patient Authorization to Disclose Personal Information

Patient: _____
(First Name) (Middle Name) (Last Name)

Address: _____
(No. Street) (City) (State) (Zip)

Date of Birth: _____ **Telephone No.:** _____

ADD Clinic of Arizona is authorized to **furnish to/receive from** (circle desired choice):

Physician _____

Phone # _____ Fax # _____

Address _____

Optional Authorization for Release of Medical Information

[ ] Do Not Release Information

I authorize ADHD Clinic of Arizona to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, test results or medical care.

Name _____ Relationship_____Phone_____
Name _____ Relationship_____Phone _____
Name _____Relationship_____ Phone _____

I authorize release of the following medical records:

□ **I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS** including information and records or copies relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

□ I **GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:**

_____

_____

I release ADD Clinic of Arizona and the Recipient/Disclosure listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to ADD Clinic of Arizona, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on __/__/__ (*Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Guardian/Parent if Minor) Date

_____ _____
Witness Signature Date

Please send information to the above address and/or fax. Thank you.

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Pain Medication Guidelines

1. If you are here to seek narcotic pain medication or oxycodone, please be aware that this clinic will not prescribe those medications. We believe that narcotics pain killers like oxycodone do not heal or cure symptoms.

Follow Up and Medicine/Prescription Refill Guidelines

1. All patients will be required to make a 30-day follow up appointment to get their refills approved. This can be a telemedicine or an in-person appointment. The class of medication and nature of treatment requires this follow up appointment every 30 days.
2. All patients are also required to make an in-person appointment at least once every 90 days, wherein a urine drug screen will be performed.

_____ _____

Patient Name **Patient Sign/Date**