METROPOLITAN NEURO BEHAVIORAL INSTITUTE - PEACEFUL MINDS

PATIENT INFORMATION FORM

____ __/__/___ M / F

PATIENT's NAME (First M Last) DATE OF BIRTH SEX

MAILING ADDRESS: ***IF PATIENT IS A MINOR, PLEASE WRITE PARENT/GUARDIAN NAME**

____ __/__/___

First Name M Last Name Date of Birth

____

Street City State Zip Code

____

Primary Phone Secondary Phone Email

BILLING ADDRESS: ***IF PATIENT IS A MINOR, PLEASE WRITE PARENT/GUARDIAN NAME** ☐ ***SAMEASABOVE***

____ __/__/___

First Name M Last Name Date of Birth

____

Street City State Zip Code

____

Primary Phone Secondary Phone Email

PRIMARY INSURANCE *(Circle)*: SELF SPOUSE CHILD

____

Insurance Plan Member/Subscriber Number Group Number

____ __ /__ /__ M / F

Subscriber Name (if not SELF) M LastName Date of Birth Sex

SECONDARY INSURANCE *(Circle)*: SELF SPOUSE CHILD

____

Insurance Plan Member/Subscriber Number Group Number

____ __ /__ /__ M / F

Subscriber Name (if not SELF) M. LastName Date of Birth Sex

I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I also understand that appointments must be cancelled *at least 48 hours in advance.* There will be a charge for cancellations not made *48 hours prior to appointment.* This is considered an out-of-pocket expense I will be responsible for.

____ ____________________

PATIENT SIGNATURE OR GUARDIAN IF A MINOR) *DATE*

METRO NEURO BEHAVIORAL INSTITUTE, PCC ● PEACEFUL MINDS, LCC

CONSENT TO TREAT

I hereby voluntarily apply for treatment from Metro NBI Practitioners or Peaceful Minds Ruth Flucker, PMHNP-BC.

I hereby authorize the release of medical information necessary to process billing claims. I also authorize payment of medical benefits to Metropolitan Neuro Behavioral Institute or Peaceful Minds Ruth Flucker, PMHNP- for all services rendered.

I understand that I am financially responsible for all charges whether they are paid by my insurance company.

I also understand that appointments **must be cancelled** at least **48 hours** not including holidays in advance to avoid late cancellation or no-show fees of **$75.00.**

Metropolitan Neuro Behavioral Institute and their affiliates participate in programs for training health care personnel. Students, interns, externs, residents, and Licensed Associate Counselors (LAC) may participate in your treatment recommendations, conduct assessments, provide counseling, or be present at various times during your sessions. You can decline "student services" at any time.

☐ Patient is a minor whose parents are divorced with joint custody in matters of treatment. Both parents must sign this consent. It is the accompanying parent's responsibility to communicate treatment changes, decisions for care, and medication changes with non-attending parent. **Legal Custody/Divorce Decree papers must be provided at patient's first appointment with both parent's signatures before minor can see the provider without exception.**

☐ Patient is a minor whose parents are divorced, and the non- accompanying parent has no legal authority in making decisions for the minor. **Legal Custody/Divorce Decree papers must be provided at first appointment before seeing the provider without exception.**

If you have any concerns or questions regarding medical students, medical interns, or medical residents you may contact Dr. Patino at (480) 464-4431. If you have any concerns or questions regarding Licensed Associate Counselors or counseling students you can contact Dedra Serafin,RN, LPC at (480) 464-4431.

Patient Name: ____________________________ Patient/ Parent Signature: ________________________________

Today's Date: ____________________________ Witness Initials______________ Date: _____________________

Lauro Amezcua-Patino, MD, FAPA
Lauren Kiraly, MMS, PA-C
Barbara Schulte, DNP, PMHNP-BC
Chitra Mathew, DNP, PMHNP-BC
Matthew Burton, MMS, PA
Peaceful Minds Ruth Flucker, PMHNP-BC
Stella Waweru, PMHNP-BC
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Dedra Serafin, MSC, RN, LPC, NCC

70 N. McClintock Dr. Suite #4 | Chandler, AZ 85226 | Phone 480.464.4431| Fax 480.464.2338
Website www.metronbi.com

Portal Website https://valantmed.com/portal/Metropolitan

METROPOLITAN NEURO BEHAVIORAL INSTITUTE, PLLC● PEACEFUL MINDS, LLC

PERMISSION TO COMMUNICATE WITH FAMILY & FRIENDS

☐ I choose to allow the people listed below to receive information regarding my appointment dates and times and billing issues. I understand this authorization may be revoked at any time. No aspects of care nor medical records will be released to them without a HIPAA compliant release of information being signed.

☐ I choose to **not allow** anyone participate in my care and am aware that only I will be able to receive information regarding my appointment dates and times, billing issues, or any aspects of my care unless it is a life-threatening emergency.

Parents: If your child is **over 18 years of age** and you are not their legal guardian, this form MUST include you for us to be able to discuss your child's appointment dates and times and billing issues.

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________

☐ I choose to allow the step-parent/s ________________________, ________________________ to bring minor to appointment, make appointments and receive information.

☐ I do not choose to allow the step-parent/s ________________________, _________________ to bring minor to appointment, make appointments and receive information.

Patient Name: ____________________________ Patient/ Parent Signature: ________________________________

Today's Date: ____________________________ Witness Initials______________ Date: _____________________

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METROPOLITAN NEURO BEHAVIORAL INSTITUTE, PLLC• PEACEFUL MINDS, LLC
CLINICAL CONDITIONS OF EVALUATION AND TREATMENT

I, ______________________________ acknowledge having scheduled a voluntary Psychiatric evaluation for diagnostic and treatment purposes with Metropolitan Neuro Behavioral Institute (Metro NBI) and/or Peaceful Minds providers.

I acknowledge that I was provided with instructions about the evaluation process, and that the evaluation may include the completion of multiple forms for the collection of clinical information, as well as an interview with a Metro NBI or Peaceful Minds provider. I understand that Metro NBI and Peaceful Minds follow a recovery model and I am expected to be responsible for my recovery by actively participating in treatment recommendations.

After completion of the initial evaluation, I may be provided with the available diagnostic findings, and I agree that at this point a decision can be made by either party to establish, or not, a provider-patient relationship. In the event of either myself refusing to continue with services; or Metro NBI or Peaceful Minds deciding to not be my provider, I will be given the name of at least 3 local psychiatric physicians or resources to find a different provider capable of providing me with a second opinion and further care.

I acknowledge that Metro NBI and Peaceful Minds practitioners will not provide me or my family with formal Psychotherapy Services beyond supportive therapy in the context of medication management and psychiatric assessment. If my Metro NBI provider recommends formal Psychotherapy Services, it is my sole responsibility to procure and secure those services. However, psychotherapy is available at this clinic at a self-pay rate.

I acknowledge that the completion of disability, accommodations, FMLA, and other forms is beyond the scope of the provider's medication management practice and appointments, and not considered part of the evaluation or medication management reimbursement fee. I will be charged a fee based on the time and complexity of the form. Emotional Support Animal letters require an appointment with a staff member who will review current laws. ***Before any forms are filled out you must discuss them with your provider at your scheduled appointment.***

I understand that my "medication management" visits are scheduled for 15 minutes. If I arrive 8 minutes late to my appointment based on our clock, I will be considered as having missed my appointment, and will be rescheduled for next available appointment. A medication refill will be provided. I understand that occasionally, providers and staff may run late on their schedules due to unexpected patient situations. I also recognize that if I don't cancel my appointment at least 48 hours (not including weekends) in advance a fee of $75.00 will be charged to my account.

Please initial:

I acknowledge that Metropolitan NBI and Peaceful Minds and its practitioners **DO NOT** provide Emergency Psychiatric or Continuous Crisis Management Services. I agree to call 911 or visit my closest Emergency Room or Psychiatric Urgent Care Center/Hospital in the event of a Psychiatric Emergency **~or~** call the Crisis Line at 602-222-9444.

I understand that Metro NBI provider schedules are filled in advance and generally do not allow for patients to be seen on an urgent basis unless there is a cancellation. I understand it is my responsibility to schedule and maintain appointments directed by the provider.

I acknowledge as part of my treatment, my provider will require me to obtain blood work and/or a urine drug screen. This may be new blood work and/or urine drug screen testing if the provider deems it a clinical necessity. If lab work was done recently through a coordinating physician, new lab work may not be necessary. Blood work and/or urine drug screens may be required on an ongoing basis throughout my treatment and my provider will discuss this with me.

I also acknowledge that Metro NBI and Peaceful Minds providers do not provide *Emergency Medication refills*. It is my responsibility to assure that an adequate supply of medications **is always maintained.** Medication refills need to be requested **at least 4-5 days** before running out of the most recent medication supply. I understand that **non-controlled substance** medication refills will be completed within **4-5 business days from request**, and that **medication prior authorizations** will be completed within **7-10 business days** from receipt of the request, depending on my insurance company. I acknowledge a controlled substance refill request completion is based on my provider availability to review and sign the prescription.

METROPOLITAN NEURO BEHAVIORAL INSTITUTE, PLLC ● PEACEFUL MINDS,LLC
CLINICAL CONDITIONS OF EVALUATION AND TREATMENT (2of 2)

Any questions regarding medications or treatment should be directed to your provider via email at nurse@metropsych.com **~or~** leave a message at 480-464-4431, **option 4** ~ or ~ request through our website www.metronbi.com

Portal Access via web https://valantmed.com/portal/Metropolitan

I am aware and agree that Metro NBI and Peaceful Minds will terminate my clinical services upon my verbal or written request. **I am aware and agree that Metro NBI and Peaceful Minds may terminate my clinical services due to the following:**

- My failure to maintain adherence with at least **2 consecutive** schedule appointments without 48 hour notice
- Any abuse or misuse of any prescribed medications or use of controlled substance(s) not reported
- Any dangerous behavior or threats of violence or harm or verbal abuse toward staff or providers
- My unwillingness to adhere to treatment recommendations, if in the opinion of the Metro NBI or Peaceful Minds providers, my lack of adherence places me or other people in danger.
- The initiation of involuntary Court Order Evaluation or Court Order Treatment
- A higher level of service is needed such as; case management and/or other community resources and supports, specialty service/treatment, as discussed with me by my provider or staff.

PATIENT EXPECTATION REMINDERS & ACKNOWLEDGEMENTS:

-I understand that my medication management visits are scheduled for 15 minutes (or as discussed with your provider); if I arrive **8 minutes late** to my appointment based on our clock, I will be considered as having missed my appointment. I will be rescheduled for the next available appointment. A medication refill **will be** provided at no charge up until my next re-scheduled appointment.

- I also recognize that if I do not cancel my appointments at least **48- hours** ***not including weekends*** a fee of **$75.00** will be placed on my account. I understand that Metro NBI/Peaceful Minds providers may run late on their schedules due to unexpected patient situations.

- Medication refills **must be requested via e-mail or website at least 4-5 business days prior to running out of your medication.** Contact your pharmacy directly **FIRST** *prior* to running out of medications. If authorization or **a controlled substance** is needed, our staff will address your requests with your provider thus needing the 4-5 days prior to running out of medications.

If you have a question about refills or any medication issues, for your convenience please FIRST email nurse@metropsych.com **~or~** fill-out the Medication Refill Form on www.metronbi.com with **your questions. Before you email or sent form to office again , call your pharmacy and see if it is waiting for pick-up.** ***NOTE:*** *If you are having a side-effect call and leave a message with your name, date of birth, your provider's name and the name of the medication at 480-464-4431 option* ***#4.***

By initialing this box, you acknowledge that you have read and understand this reminder:

- I acknowledge as part of my treatment, my provider will require me to obtain blood work. This may be new blood work if the provider deems it necessary or from a coordinating physician if the lab works is recent. This will be necessary on an ongoing basis throughout my treatment and my provider will discuss this with me.

- I acknowledge that the recovery model is used to help me reach my wellness goals; I am expected to actively participate in treatment recommendations, gain/maintain active social supports through community resources, and seek therapy services as directed. I also acknowledge I am responsible and accountable for my own care needs and will ensure I provide the clinic with the necessary information/documents needed to support my recovery goals maintaining the same respect for all staff members as I expect from the clinic personnel.

I understand that in the event of service being terminated (except in cases of involuntary commitment) I may be provided with a **30-day supply** of medications (if applicable) and the name of three local Psychiatrists or resources to find another provider that may be available to provide me with Clinical Psychiatric Services. I also understand I may request a copy of this agreement at any time during treatment.

Patient Name: ____________________________ Patient/ Parent Signature: ________________________________

Today's Date: ____________________________ Witness Initials______________ Date: _____________________

METRO NEURO BEHAVIORAL INSTITUTE, PCC ● PEACEFUL MINDS, LCC

CONSENT TO TREAT

Patient Name________________________________ Date of Birth___________

I have been allowed to review and/or have received Metropolitan Neuro Behavioral Institute and Peaceful Minds Notice of Privacy Practices.

____ Today's Date: __________

Patient's Signature or legally authorized individual

****You May Refuse to Sign This Acknowledgement****

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For Office Use Only

☐ Metropolitan Neuro Behavioral Institute ☐ Peaceful Minds; could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited it
- ☐ An emergency situation prevented us
- ☐ Other (please specify)

Employee Signature: _________________________________ Date: __________

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Terms of Agreement for Patients with AHCCCS Insurance as Secondary Insurance Seeking Treatment

☐ **Not applicable** (Check here if you do not have AHCCCS as a primary or secondary insurance policy.)

______________________________ ______________________

Patient signature Date

--------------------------------------****ONLY FILL BELOW IF YOU HAVE AHCCCS****--------------------------------------

1. I understand that Metro NBI or Peaceful Minds do not hold a contract with Arizona Health Care Cost Containment System (AHCCCS) insurance as primary insurance and hereby confirm that I do not have AHCCCS insurance as a primary policy.

   __________________ (initial)

2. I confirm that I have private insurance as my primary policy and AHCCCS insurance as a secondary policy.

   __________________ (initial)

3. I understand and agree to the following terms as a patient receiving treatment:

   a. If my primary (private) insurance does not cover a service provided at Metro NBI or Peaceful Minds and/or a medication prescribed to me by my provider, I am solely responsible for the out-of-pocket cost of the service and/or medication.

      __________________ (initial)

   b. Metro NBI or Peaceful Minds <u>cannot</u> and <u>will not</u> submit claims to AHCCCS.

      __________________ (initial)

   c. Metro NBI or Peaceful Minds will not be responsible for prior authorizations for medication coverage through AHCCCS or The Regional Behavioral Health Authority.

      __________________ (initial)

________________________________ ______________________

Patient signature Date

If you are unable to agree to the terms provided in this agreement and need help obtaining a provider who can treat you, you can call the AHCCCS toll-free number at 1-800-654-8713 or visit the AHCCCS website at http://www.azahcccs.gov

____ ______________________________

Employee witness Date