Intuitive Psychology, PLC
...behavioral medicine for body, mind and spirit

5635 North Scottsdale Road Scottsdale, AZ 85250
Phone: 480-261-4061
Email: admin@intuitivepsychologyplc.com

Confidential Health History

Patient Name:_____ Date of Birth:_____

Please provide the following information about your general health and your health history.

- Please check √ areas of personal health history. Place an X in areas of family history.

○ Alcohol use/Drug use	○ Ear/Nose/Throat Disease or Infection	○ Migraines/Headaches
○ Allergies: Pollen, Dust, Animal	○ Epilepsy/Seizure Disorder, Convulsions	○ Muscle/Tendon Disorders
○ Allergies: Medications	○ Hysterectomy	○ Prosthetic Implant/Artificial Limbs
○ Asthma, Bronchitis	○ Female Organ Irregularity, Abnormal Pap, Menstrual	○ Reconstructive/Cosmetic surgery
○ Arthritis, Gout	○ Gallbladder	○ Sexually Transmitted Disease
○ Eating Disorder: Anorexia, Bulimia	○ Heart Problem or Condition	○ Skin Disorders/Lesions/Cancer
○ Bone/Joint Condition	○ Hepatitis/Liver Disorder	○ Steroid Use: Prednisone, Anabolic
○ Back, Neck, Spine, Disc Problem or injury	○ Hormonal/Thyroid/Pituitary Disorder	○ Stroke
○ Birth Defects/Deformity	○ HIV/AIDS	○ Tumors, Cysts, Polyps, Growths
○ Blood Disease: Anemia, Leukemia	○ Immune System Disorder, Lupus	○ Ulcers, Digestive Disorders
○ Blood Vessel, Circulation Disorder	○ Stomach/Colon/Chron's Disease	○ Weight Problems
○ Breast Disease	○ Intestinal Disorders	○ Other, explain: ○ _____
○ Breast Implants (L/R)	○ Kidney/Urinary Tract Condition or Infection	
○ Broken Bones/Bone Disease	○ Lung Condition or Infection	
○ Cancer of Any Type	○ Male Organ Irregularity or Condition: Prostate, Impotence	
○ Concussion/Head Injury	○ Nervous Sys Cond. Dementia	
○ Diabetes	○ Mental: Nervous, Depression, Anxiety	

Details for items marked above:_____
_____
_____
_____

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Please list all current medications:

Medication Name:_____ Dosage:_____ Frequency:_____
Medication Name:_____ Dosage:_____ Frequency:_____
Medication Name:_____ Dosage:_____ Frequency:_____
Medication Name:_____ Dosage:_____ Frequency:_____
Medication Name:_____ Dosage:_____ Frequency:_____
Medication Name:_____ Dosage:_____ Frequency:_____
Medication Name:_____ Dosage:_____ Frequency:_____
Medication Name:_____ Dosage:_____ Frequency:_____
(If additional space is needed please attach a separate sheet of paper or feel free to use the back of this form)

Please check any of the following areas that you have experienced:

○ Head Injury	○ Convulsions
○ Loss of Consciousness	○ Other neurologic diagnosis
○ Seizures	Explain:_____

Have you ever smoked? ___Yes ___No If yes, number of years: _____ Typical Daily Use or Quit Date: _____

Do you drink alcohol? ___Yes ___No If yes, number of years: _____ Typical Daily Use or Quit Date: _____

Please state the primary reason for this visit: _____

By signing below you agree to the following: I attest that the information I have provided is true and correct to the best of my knowledge.

_____ _____ _____
Patient/Guarantor Signature Date Dr. Initials

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Legal Name_____ DOB: _____
Address: _____
City_____State_____Zip Code_____
Home Phone#:_____Daytime Phone_____
Dates of Treatment_____SS#_____
Purpose of Disclosure: _____Continuing Medical Care_____Attorney Request_____Self _____Other

I hereby authorize Intuitive Psychology, PLC to _____release to the requestor and/or _____obtain the following medical records, including those which may contain confidential HIV/AIDS-related information, confidential communicable disease related information, and/or information relating to mental health and/or alcohol/drug use:

_____Initial Examination
_____Consultations
_____Progress Notes
_____Hospital Records
_____Lab Results
_____Imaging Results
_____Psychological/Neuropsychological Reports
_____Verbal Communication
_____Other:_____

Requestor/Provider: _____
Address:_____
City:_____State:_____Zip Code:_____
Telephone #: _____Fax#:_____
Contact Person:_____

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, by notifying Intuitive Psychology, PLC in writing. This consent will expire automatically on year from the date on which it was signed. Any disclosure of medical information by the recipient(s) is not authorized without specific consent of the patient, parent or legal guardian. I will allow information to be faxed if necessary.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian or Authorized Person/Relationship Date

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Sari Roth-Roemer, Ph.D.

Patient's Informed Consent of Practice, Policy and Procedure

Please read the following information carefully. It describes my policies and the related practices to be followed as part of the therapy services I will provide you.

Professional Information

I hold a license from the state of Arizona to practice psychology. I received my masters in counseling from Harvard University. I received my doctorate in counseling psychology from Arizona State University. I completed a two-year postdoctoral fellowship in behavioral medicine and pain management at the University of Washington and the Fred Hutchinson Cancer Research Center. I am a member of the American Psychological Association. I am a medical psychologist. This means I have specialized training in working with patients who have medical illnesses. I also specialize in pain management, cognitive testing, geropsychology and intuitive psychology. I strive to maintain a comfortable environment, where you can feel at ease to discuss whatever you find important, and where you can work towards reaching your goals in a timely manner.

Benefits of Treatment

While there is every expectation that you will notice improvement, there is no guarantee that you will feel better as a result of therapy. Because therapy is a cooperative effort between you and me, you are expected to be an active participant in your therapy. This means you will need to do some work on your own between sessions. During the course of therapy material may be discussed which is upsetting in nature. This may be necessary for you to resolve what is bothering you. I expect you to discuss any concerns that you have about your therapy with me. Of course you have the right to refuse or terminate treatment at any time. But, you must recognize that there could be personal consequences to your recovery if you fail to complete treatment.

Appointments, Cancellations, Billing and Payments

Every effort will be made to schedule appointments that are mutually convenient. If it becomes necessary for you to cancel, at least 24 hours notice must be given. My office will confirm appointments prior to your scheduled time. A typical therapy "hour" is a 45-50 minute appointment. Billing and payment policies are outlined in detail on my Professional Policy and Procedures form, please read this carefully. You should be aware that for claims to be processed, insurance companies require a diagnosis and, occasionally, other information. By law, such information cannot be released by insurance companies without your specific, informed consent.

Contacting Me

My phone is answered by receptionist Monday through Friday on a part-time basis. You may leave a message and I will make every effort to get back to you on a timely basis. If you are unable to reach me, and you feel you cannot wait for me to return your call, you should call your primary care physician or the emergency room at the nearest hospital. You may also try calling the EMPACT psychological crisis line at 480-784-1500.

If a crisis arises outside of business hours, you may call the office and you will be given directions how to leave a message for the on-call psychologist. (***If your phone has anonymous call-blocking please make sure to turn off this feature.***) This number is only for problems that cannot wait to be handled during normal business hours.

Confidentiality

Intuitive Psychology, PLC

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Communications between my patients and me are confidential, in accord with professional ethics and in compliance with the law. However, Arizona law also specifies certain limitations to this confidentiality. While these limits may not be at all relevant to your particular situation, I am legally obligated to inform you about them. The following are conditions in which disclosure can be made without your consent. I must disclose information:

1. In order to protect you or others if:
    a. I believe that you present a danger to yourself and refuse to accept appropriate treatment;
    b. you tell me of an actual intent to harm another person;
2. In case of child or elder abuse, which must be reported to appropriate state agencies.

Under these circumstances, I am required to take protective actions that may include: notifying the potential victim, notifying the police or appropriate agency, or seeking appropriate hospitalization. If I believe that you are at risk of harming yourself, my only treatment goal is going to be to keep you safe and alive. I will do whatever I need to do to protect you which includes notifying and involving members of your family. If this is unacceptable to you, then I will need to refer you elsewhere. You should know that these situations have rarely arisen in my practice. Should such a situation occur, I would make every effort to discuss it with you before taking any action.

While it is not legally required, I may also disclose information under the following circumstances:

3. In order to collect debts or to protect myself in a court action brought on by you.
4. In certain legal proceedings should a court of law issue an order signed by a judge requiring the release of confidential information.
5. With colleagues about my work with you (<u>never</u> revealing your identity) to provide the best services possible. In any case, only appropriate and necessary information will be provided.

Please be aware, if asked to go to court on your behalf, my fee for services is $300 an hour.

As I am sure you are aware I am required to keep appropriate records of our work together. These notes will be brief and will only convey general information that communicates the progress you are making. You are entitled to receive a copy of your records unless I believe that seeing them would be emotionally damaging to you. In such a case I will be happy to provide them to another psychologist of your choice. If another physician referred your case to me, your progress will be communicated to the physician. Of course, whenever you wish to give expressed, written consent, I can share information about you to whomever you wish. Otherwise, whatever specifics we talk about, stay confidential between us.

Please be sure to raise any questions you may have regarding this form with me before signing.

_____ _____

Signature Date

Informed consent and limits of confidentiality have been discussed directly with this patient and questions have been answered.

_____ _____

Sari Roth-Roemer, Ph.D. Date

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❑ Section 1: Patient Demographics

Required fields are in Bold print

Patient Name: _____ **Date of Birth** _____ Nickname: _____

Street Address _____ **City** _____ **State** ____ **Zip** _____

Home Phone _____ **Mobile Phone** _____ **Email**: _____

Gender: ❑ Female ❑ Male **Marital Status**: ❑ Married ❑ Single ❑ Other **Patient Social Security** _____

Employment Status: ❑ Full time ❑ Part Time ❑ Unemployed ❑ Retired ❑ Disabled **Employer Name**: _____

Employer Address _____ **Work Phone**: _____

Student Status: ❑ Full Time ❑ Part Time ❑ Non-Student **If student, School Name**: _____

Emergency Contact Person _____ Relationship _____ Phone _____

Referring Physician and/or PCP Name & Phone Number _____

❑ Section 2: Primary Insurance Plan and Responsible Party Information (*for Blue Cross patient only*)

Insurance Plan Name _____ **Mailing Address** _____

City _____ **State** _____**Zip** _____ **Phone** _____

Policy or ID Number: _____ **Group #** _____ **Effective Date**: _____

If the patient is NOT the Insured on the above listed plan, the following information MUST be completed:

Insured's Name _____ **Date of Birth** _____**Gender**: ❑ Female ❑ Male

Insured's Social Security # _____ **Relationship to patient**: ❑ Spouse ❑ Parent ❑ Guardian ❑ Other

Address, if different than patient:_____ City_____ State _____ Zip _____

Home Phone _____ **Work Phone** _____ **Employer Name**: _____

❑ Authorization for Assignment & Release (All patients/guarantors must sign and date this section)

I authorize my insurance benefits to be paid directly to the practice/doctor. I authorize my medical information to be released as required to justify medical necessity on billing documents. I understand and agree to be responsible for any out of network or non-covered services that may be provided. I understand that I am financially liable for payment for services rendered and that I am responsible for providing all pertaining insurance information to expedite insurance reimbursement. I agree to pay my required co-pay at the time of service and/or agree that I will pay in full for services rendered at the time of service.

Patient/Guarantor Signature _____ Date _____ Time _____

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Professional Policy and Procedure Agreement

Please read the following information very carefully as it describes the policies, procedures, and related practices to be followed as a part of therapy services provided by Dr. Sari Roth-Roemer at Intuitive Psychology, PLC. This information is provided for your benefit and to facilitate your understanding of our policies and procedures as they apply to you. Please feel free to ask questions if you need to understand more about this relationship. After reading this material, please indicate your understanding and approval by signing this document, and giving it to your provider.

Payment Policies

Your Arizona Medical Psychology, PLC psychologist is an Arizona State licensed doctoral level psychologist. ***We are fee for service providers. This means that you pay for your services at the time you receive them and we will provide you with what you need to collect from your insurance company.***

We encourage every patient to verify their benefits for psychological services with their insurance company prior to their first appointment, so you will have a clear understanding of your benefits for out of network psychological services and what your financial responsibility will ultimately be. It is your responsibility to obtain any necessary pre-authorizations required to see Dr. Roth-Roemer before your scheduled appointment.

Insurance companies classify us as an out of network provider, except for Blue Cross. We do not bill any health insurance companies, other than Blue Cross. We collect full payment at the time of your visit and then your insurance company will reimburse you directly after you submit your charges to them. We provide receipts to submit to your insurance company for reimbursement. The receipts contain all the information a health insurance company would need to reimburse you for your visit. Reimbursement for psychological services are based upon your individual out-of-network benefits and coverage. Depending on your out of network benefit, you may be reimbursed for up to 80% of the appointment. Also, if you plan on billing insurance for reimbursement of your visit, you will need to obtain a prescription from your physician prior to your first appointment. If you do not plan on billing insurance, you do not need a prescription. For more assistance, please refer to our insurance billing worksheet to use when you contact your insurer.

It is your responsibility to check to see what your insurance coverage is prior to your appointment with Dr. Roth-Roemer.

Telephone Therapy

When therapy is provided over the telephone during or after office hours, you will be responsible for paying for these therapy services. Many medical plans do not cover these types of services and you should know that it is likely you will not be reimbursed.

Cancellations

If you need to cancel an appointment, at least 24-hour notice is required. As a courtesy, our office will confirm appointments the day before the scheduled appointment. If you do not cancel at least 24 hours before your appointment time, you will be charged the full rate for the missed appointment.

Assignment of Insurance Benefits For Blue Cross Patients

I hereby authorize Intuitive Psychology, PLC to receive payment for services rendered to me, directly from my insurance plan, unless prohibited by my carrier for some reason. If the insurance company renders payment directly to me, I agree to forward the funds and a copy of the Explanation of Benefits to Intuitive Psychology, PLC, 5635 N. Scottsdale Rd, Scottsdale, AZ 85250. All payments must be made payable to Intuitive Psychology, PLC.

Acknowledgement of Understanding

I have read the information contained in the policies and procedures for Intuitive Psychology, PLC psychological services and acknowledge full responsibility for any charges incurred by me and or my family, regardless of insurance eligibility. A photocopy or facsimile of this authorization will be considered as valid as the original.

_____ _____

Patient/Guarantor Printed Name Patient/Guarantor Signature

_____

Date