



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

5635 N. Scottsdale Rd Suite 170, Scottsdale, AZ, 85250 Phone: (480) 261-4061 Fax: (480) 535-5548 Admin@IntuitivePsychologyPLC.com

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 returning it to our office.

PAYMENT POLICIES

Dr. Roth-Roemer is an Arizona State licensed doctoral level psychologist. ***She is a fee for service provider. This means that you pay for your services at the time you receive them and we will provide you with a superbill to collect reimbursement 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. 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 do not bill any health insurance companies directly. We provide you with a receipt to submit to your insurance company for reimbursement. The receipt contains 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 may need to obtain a prescription from your physician prior to your first appointment to document medical necessity. If you do not plan on getting reimbursed from your insurance company, you will not need a prescription. For more assistance, please refer to our insurance billing worksheet to use when you contact your insurer.

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

As noted in your intake phone call, Medicare patients may not seek reimbursement from their insurance company. Dr. Roth-Roemer has opted out of Medicare and is not a Medicare provider. If you are a Medicare patient you will not be able to seek reimbursement from Medicare or any other secondary insurance company. This is a Federal rule that must be adhered to. You will be provided with an additional Medicare beneficiary contract to complete and sign on the day of your appointment.

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 you may 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. *Please note, if you do not cancel at least 24 business hours before your appointment time, you will be charged the full appointment rate for the missed appointment.*

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. I understand that I am financially liable for payment for services rendered. I agree that I will pay in full for services rendered at the time of service.

Patient/Guarantor Printed Name

Patient/Guarantor Signature

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 medical psychologist. This means I have specialized training in working with patients who have medical illnesses. I also specialize in brain injury, pain management, cognitive testing, and geropsychology. 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 your appointment please be sure to call the office at least 24 business hours in advance to avoid a cancellation fee. To ensure that we receive your cancellation request please call the office directly, do not text or email. 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.

Contacting Me

My phone is answered by receptionist Monday through Thursday on a part-time basis. Up to date office hours are noted on our voicemail message. Our office number is 480-261-4061. You may leave a message and we 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. For life threatening emergencies always call 911.

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Confidentiality

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 (never 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 starts at \$350 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



Patient Demographics

Patient Name _____

Date of Birth _____ Gender Female Male Nickname _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Email _____

Marital Status Married Single Divorced Widowed

Employment Status Full time Part Time Unemployed Retired Disabled

Employer Name _____ Work Phone _____

Employer Address _____

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 _____



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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.

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

<input type="checkbox"/> Head Injury	<input type="checkbox"/> Convulsions
<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Other neurologic diagnosis
<input type="checkbox"/> 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