**Arizona ADHD Center**

**11000 N Scottsdale Road, Ste 250, Scottsdale AZ 85254**

**Phone: 480-900-4294**

**Office Policies and Procedures**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 8:00 am – 5:00 pm with lunch from 12 pm – 1:00 pm (hours may vary from time to time). 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. **AZ ADHD Center reserves the right to bill $50.00 for each No-Show appointment.**

**TEST RESULTS**

Our medical assistant will usually contact you by phone regarding your test results to schedule an appointment for follow-up. **You will be subject to co-pay if your plan requires a co-pay for visits**. If you 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.

**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 becomesa 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 give consent to be treated. I have reviewed and received an Advanced Care Directive and a copy of my patient rights.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Print Name Date

**11000 N Scottsdale Road, Ste 250, Scottsdale AZ 85254**

**Phone: 480-900-4294**

**No Show Appointment Policy**

AZ ADHD Center 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 24hours 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 24 hours ahead of time 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 scheduled appointments you may be notified by mail that you have been discharged from the practice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/ Guardian/Parent Relationship Date

Arizona ADHD Center

**11000 N Scottsdale Road, Ste 250, Scottsdale AZ 85254**

**Phone: 480-900-4294**

**Patient Information**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Sex: M/F Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Apartment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If the need arises, the doctor/receptionist may leave a message on my (circle one that apply)*

Home phone Cell Phone Family Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_ Sex: M/F Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Insurance Information**

**Primary Insurance Company Name:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Company Name:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please make sure you update your information with us if there are any changes. Thank you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/ Guardian/ Parent Relationship Date

**11000 N Scottsdale Road, Ste 250, Scottsdale AZ 85254**

**Phone: 480-900-4294**

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? | | |

|  |  |  |
| --- | --- | --- |
| **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? | □Yes | □No |

|  |  |  |
| --- | --- | --- |
| **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 |

**11000 N Scottsdale Road, Ste 250, Scottsdale AZ 85254**

**Phone: 480-900-4294**

***ACKNOWLEDGEMNET 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 (\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_ Written Communication

Okay to leave message with instructions Okay to mail to home address

Okay to leave message with call-back number only Okay to mail to work/office address

Okay to fax to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Telephone (\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Okay to leave message with instructions

Okay to leave message with call-back number only

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print) Date of Birth

**11000 N Scottsdale Road, Ste 250, Scottsdale AZ 85254**

**Phone: 480-900-4294**

***Patient Authorization to Disclose Personal Information***

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(First Name) (Middle Name) (Last Name)

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(No. Street) (City) (State) (Zip)

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phoenix Family Medical Clinic is authorized to **furnish to/receive** **from/ translate / interpret using** (circle desired choice):

Interpreter/ Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 released AZ ADHD Center and the Recipent/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 AZ ADHD Center, 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.**

**11000 N Scottsdale Road, Ste 250, Scottsdale AZ 85254**

**Phone: 480-900-4294**

**Pain Medication Guidelines**

1. If you are here just 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 anything.

Follow Up and medicine 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 appointment or an in-person appointment. The class of medication and nature of treatment require this follow up appointment every 30days.
2. All patients are required to make an in-person appointment at least once every 90 days, wherein a urine drug screening test will be performed.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name/Sign Date**