



# NOWLIN PSYCHIATRIC CLINIC P.C.

## INFORMED CONSENT

I understand that care is a cooperative effort between me and my provider. I will work with my provider in a cooperative manner to resolve my difficulties.

I understand that confidentiality of records and information about me is protected by state and federal laws. I also understand that state and local laws require the provider to report all cases of physical or sexual abuse or neglect of minors or elderly and cases in there exists a danger to self and/or to others.

I understand that I have chosen to receive services voluntarily and that I may terminate care at any time. I will discuss any concerns I have with my provider.

I understand that during the course of my care, material may be discussed which will be upsetting in nature and this may be necessary to help my resolve my problems.  
I have read and understand the HIPPA Notice of Privacy Practices

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Signature of Patient/Legal Guardian

Date

## FINANCIAL INFORMATION

**AS OF 08/26/16, IF YOU MISS AN APPOINTMENT WITHOUT CANCELLING BEFORE 4:00 PM THE BUSINESS DAY PRIOR TO YOUR APPOINTMENT YOU WILL BE CHARGED A \$60 FEE. MISSED APPOINTMENTS ARE NOT COVERED BY INSURANCE COMPANIES THEREFORE THE CHARGES WILL BE YOUR RESPONSIBILITY.**

Some managed mental health programs involve a co-payment. It is your responsibility to determine whether or not services are covered under your plan and to pay any charges not covered.

In addition current insurance guidelines state that the duration of standard office visits vary with the services provided, and their reimbursements are based on that length of time. Should additional time be needed, you may be subjected to additional charges.

The following services are generally not covered by insurance benefits: extended telephone calls (over 5 minutes), letters, reports, copies of medical records and faxes. Should you require any of these services, you will be charged an additional fee. The fee may vary depending on the request.

**ALL COPAYS MUST BE PAID AT THE TIME OF THE APPOINTMENT  
I HAVE READ AND UNDERSTAND THE ABOVE:**

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Signature of Patient/Legal Guardian

Date

NOWLIN PSYCHIATRIC CLINIC, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and professional codes of ethics. It also describes your rights regarding how you may gain access to and control you PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice at any time. Any new Notice will be effective for all PHI that we maintain at that time. We will provide you with a copy of any revised Notice of Privacy Practices at your request.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**FOR TREATMENT:** Your PHI may be used and disclosed by those who are involved in your care and for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**FOR PAYMENT:** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. This may include determination of eligibility or coverage for insurance benefits, processing claims with your insurance company reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

**FOR HEALTH CARE OPERATIONS:** we may use or disclose, as needed, your PHI in order to support our business activities including, but no limit to quality assessment

activities, employee review activities, licensing, and conducting or arranging for other business activities.

Your PHI will also be used by our staff to call/leave appointment reminders UNLESS YOU REQUEST IN WRITING THAT THIS NOT BE DONE. You will be asked for a telephone number where we can reach you or leave a reminder message.

We may call you by name in the waiting room when your provider is ready to see you for your appointment.

When communicating by telephone, we will provide information to patients only about their own care, or to the parents/legal guardians of minors. Exceptions to this are noted elsewhere in this Notice.

Our staff will collect administrative information from you. Clinical information is obtained only by your provider.

**REQUIRED BY LAW** Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**OTHER USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR CONSENT.** We may use your PHI without your consent or authorization in the following situations: a) when disclosure is required by federal, state, or local law; b) when abuse or neglect is suspected; c) for judicial and administrative proceedings; d) in the event of a patient's death; e) in emergency situations; f) in situations where a family member is involved in your care; g) if health oversight is suspected; h) if requested by law enforcement agencies; i) if requested by national security agencies; j) if requested by public health agencies; k) for Worker's Compensation purposes; l) if it is our duty to warn that you are a danger to yourself, others, or the property of others; m) mandatory government audits or investigations; n) court orders; o) for research purposes.

**Verbal Permission:** We may use or disclose your information to family members who are directly involved in your treatment with your verbal permission.

**With Authorization:** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization which may be revoked.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your requests in writing to: Nowlin Psychiatric Clinic, P.C. 8414 East Shea Blvd, Suite 102; Scottsdale, AZ 85260. You may incur reasonable charges for these requests.

- a) You have the right to inspect and copy PHI that may be used to make decisions about your care. Your right will be restricted only in those situations where there is compelling evidence that access would cause harm to you or your child. Psychotherapy and medication management notes have special protection under HIPPA. These notes are intended for the sole use of the clinician providing your care. The right to view or get copies of your PHI does not include access to psychotherapy and medication management.
- b) You have the right to ask us to amend any information in your PHI that you feel is incorrect or incomplete, although we are not required to agree to the amendment.
- c) You have the right to ask us to amend any information in your PHI. The list will not include disclosures to which you have already consented or disclosures made prior to 08/01/2011. We may require a reasonable fee if you request more than one accounting per 12-month period.
- d) You have the right to request a limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- e) You have the right to request that your PHI be sent to you at an alternate address or by an alternate method, provided this can be done without our undue inconvenience.
- f) You have the right to keep a copy of this Notice.

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**Signature of Patient/Legal guardian**

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**Date**

**Mary C. Nowlin, DO, DLFAMA, DFAACAP, FACN**

Child Adolescent and Adult Psychiatrist

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7050 West Bell Road

Suite 12

Glendale AZ 85308

8414 East Shea Blvd.

Suite 102

Scottsdale AZ 85260

Phone: 623-322-7301

Fax: 623-337-9562

## **CONSENT FOR TREATMENT**

**As you know, I share an office with Counselors at the Glendale office and at the Doan Counseling in Scottsdale AZ. I am an independently practicing professional and share only office space with these two Counseling Centers. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no one else can have access to them without your specific, written permission.**

**The undersigned patient or responsible party (parent legal guardian or conservator) consents to, and authorizes services, by Mary C. Nowlin, DO. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.**

**The undersigned understands that he/she has the right to:**

- 1. Be informed of and participate in the selection of treatment modalities.**
- 2. Receive a copy of this consent.**
- 3. Withdraw this consent at any time.**

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Signature of patient

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Date signed

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Signature of parent, Legal Guardian or Conservator

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Date Signed

# TREATMENT CONSENT

I/we are providing consent for \_\_\_\_\_  
Patient's name  
to receive treatment for \_\_\_\_\_  
Disorder being treated  
with the following treatment(s):

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I/we understand the following:

- That I/we have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options, including \_\_\_\_\_  
\_\_\_\_\_
- That I/we have had the opportunity to have all questions answered to my/our satisfaction.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.
- That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

\_\_\_\_\_ Date \_\_\_\_\_  
Patient signature\*

\_\_\_\_\_ Date \_\_\_\_\_  
Parent/legal guardian

\_\_\_\_\_ Date \_\_\_\_\_  
Treatment provider

\* If patient is a minor, signature may be required, depending on state law.

**THE NOWLIN PSYCHIATRIC CLINIC, PC**

**7075 West Bell Road Suite 12**

**8414 East Shea Blvd Suite 102**

**Glendale AZ 85308**

**Scottsdale AZ 85260**

**Phone: 623-322-7301 FAX : 623-337-9562**

**PRIMARY CARE PHYSICIAN NOTIFICATION LETTER AND AUTHORIZATION  
FOR EXCHANGE OF INFORMATION WITH PRIMARY CARE PROVIDERS  
(PCP)**

This information is released for the purposes of management and coordination of my medical and behavioral health care by my health care providers.

I hereby authorize Mary Nowlin, DO to disclose health care information related to the treatment of \_\_\_\_\_

Date of Birth \_\_\_\_\_ to my Primary Care Provider (PCP)

PCP \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

I understand that my records are protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. A photocopy of the authorization will be considered as valid as the original.

I DO \_\_\_\_\_ or I DO NOT \_\_\_\_\_ want my PCP notified.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_



