Nowlin Psychiatric Clinic
Child/Adolescent Intake Information

Child's Name_________________________________BirthDate__________Age_______
Parent/Guardian's Name(s)______________________________Date__________________
Address:____
City/State/Zip_____________________________ Email____________________________
Phone: Home:__________________ Work______________________________________
Emergency Contact: Name____________________________ Relationship_____________
Primary Care Physician:___________________________Phone:______________________
Last seen by Physician: ________________________for_____________________________
Current Medical Conditions:
____
____
CurrentMedications/dosages:____
____

Insurance Information

Name of Policy Holder:________________________ Policy Holder Birthdate___________
ID#________________________________Employer________________________________
Soc. Security # of Policy Holder____
Insurance Carrier:____
Address of Insurance Co:____
____
Phone # on Insurance Card____

Insurance Authorization

I authorize release of information, including copies of medical records to my insurance carrier, managed care company, clinical/case manager, primary care physician, as needed to fulfill insurance requirements or processing of my claims or as needed for treatment planning and management required by my insurance carrier.
Signature________________________________Date__________________________________

Assignment of Benefits

I authorize payment of insurance benefits for services rendered to Nowlin Psychiatric Clinic, P.C.
Signature________________________________Date__________________________________

Nowlin Psychiatric Clinic, P.C.
Informed Consent

I understand that care is a cooperative effort between my child and their provider. I understand that during the course of my child's care, material may be discussed which will be upsetting in nature and this may be necessary to help him/her resolve his/her problems. I will work in a cooperative manner to support the care. I understand that I have chosen to have my child receive services voluntarily and that I may be terminated at any time. I will discuss any concerns I may have with the provider. I understand that confidentiality of records and information about my child is protected by state and federal laws.

I have read and understand the HIPPA Notice of Privacy Practices:

____ ________________________

Signature of Parent/Legal Guardian Date

Financial Information

AS OF 08/26/2016, 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.

As you are probably aware, mental health benefits have been subject to a great many changes over the past few years. We have continued to provide the same high quality of patient care while adjusting to the many cost cutting measures that have been put into effect. However, these policies must be implemented:

1. 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.
2. 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.
3. **ALL COPAYS MUST BE PAID AT THE TIME OF THE APPOINTMENT.**

I have read and understand the above:

____ ________________________

Signature of Parent/Legal Guardian Date

Please list the problems that are of most concern to you at this time regarding your child.

1.____

2.____

____

3.____

____

4.____

____

Has your child received counseling previously? _____Yes ______No
Was previous counseling for same or similar problem? _____Yes _____No
How long was your child in counseling?____
Do you suspect/know of any drugs or alcohol problem with your child ___Yes ____No

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FAMILY HISTORY

Name	Relationship	Birthdate/age	Occupation

PREGNANCY

During pregnancy did the child's mother have:

German measles Y N
Anemia Y N
Diabetes Y N
Kidney problems Y N
Drugs or Medicine Y N
High Blood Pressure Y N
High Fever (103 or higher for 3 days or more) Y N
Severe emotional problems Y N
Vaginal infection, discharges or bleeding Y N
Mother ever have a miscarriage Y N
Miscarriage from previous pregnancy Y N
Miscarriage after this child Y N
Miscarriage with any other pregnancies Y N

BIRTH

How long was this child's mother in labor?____
Birth Weight_______lbs._______oz.
Was anesthetic used?____
Were there any injuries to the baby at birth?_______________________________________
Did the baby have any problems breathing at birth?__________________________________
Was an operation performed to deliver the baby?____________________________________
Did the baby need blood at birth?____
Were any instruments used to deliver the baby?_____________________________________
Was the baby placed in an incubator?____
Did the baby have yellow jaundice at birth?_______________________________________

MEDICAL HISTORY

Has your child ever had the following?
Measles Y N Asthma Y N Mumps Y N
Chicken Pox Y N Blow on the head Y N High fever (104 or higher for 3 days or more) Y N Scarlet Fever Y N Medication for behavior problems Y N
Rheumatic fever Y N Seizures Y N Allergies to food Y N
Anemia (low iron or sickle cell) Y N Other allergies Y N
Repeated or prolonged hospitalization Y N Tics/twitches Y N

DEVELOPMENT

At about what age did your child first…?
Sit up_____________ Crawl____________Stand alone ____________ Walk by self_____
Feed Self __________ Dress self _________ Speak first real worlds___________________
Speak first real sentences _______________ Become completely toilet trained_________
Help with household tasks______________ Ride a tricycle__________Bicycle_________
Tie own shoes_____________

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 your 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 limited 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.

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) 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 request in writing to: Nowlin Psychiatric Clinic, P.C. (for Scottsdale patients only) 8414 East Shea Blvd, Ste 102, Scottsdale AZ 85260 and (for Glendale patients only) 7075 W Bell Rd Suite 12, Glendale AZ 85308). 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. Psychotherapy and medication management 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 notes
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. 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.

This Notice is effective August 24, 2016

______________________________________ ______________________________

Signature of Parent/Legal Guardian Date

TREATMENT CONSENT

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

____

____

____

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.

MARY C. NOWLIN, DO

7075 West Bell Road Ste 12
Glendale AZ 85308

8414 East Shea Blvd. Ste 102
Scottsdale AZ 85260

Phone: 623-322-7301
Fax: 623-337-9562

Release of Information

I hereby authorize: ☐ Mary C. Nowlin DO

To:
- ☐ Release information to:
- ☐ Obtain information from:
- ☐ Exchange information with:

Name: ______________________________
Address: ______________________________
____
____
Telephone: ______________________________

The information requested or authorized for release or exchange pertains to:

- ☐ Initial Evaluation, Psychiatric Note, Labs, Treatment summary, medical tests Drug/Alcohol Use/Abuse
- ☐ Education, School Letters (504, IEP Plan, etc)
- ☐ Continuity of Care, Discuss Treatment
- ☐ Insurance, Billing Inquiries, FMLA Letters
- ☐ Schedule/Cancel appointments

This authorization is valid for 90 days from the date below or ___________, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

______________________________ ____________________
Patients Name Date of Birth

______________________________ ____________________
Patients Signature Date

______________________________ ____________________
Guardian's Signature (if patient is a minor) Date

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_______________

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

Child Adolescent and Adult Psychiatrist

7050 West Bell Road
Suite 12
Glendale AZ 85308

8414 East Shea Bvd.
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.**

______________________________________	______________________________________
Signature of patient	Date signed
______________________________________	______________________________________
Signature of parent, Legal Guardian or Conservator	Date Signed