DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

PATIENT REGISTRATION FORM

Date: ______________________

Name: ______________________ Nickname: ______________________ Sex: __________

Date of Birth: ______________________ Age: __________ SSN: ______________________

Address: ____
(number, street, box, apt, space) (city) (state) (zip)

Home Phone: ______________ Work Phone: ______________ Cell phone: ______________

Email:

Marital Status: Spouse/Partner's name:

Employer: ____
(name) (occupation) (address)

Referred By: Family Physician:

Emergency Contact: ______________________ Phone: ______________ Relationship: __________

Members of the household:
Name: ______________________ Age: ______________ Relationship to patient: ______________
Name: ______________________ Age: ______________ Relationship to patient: ______________
Name: ______________________ Age: ______________ Relationship to patient: ______________

RESPONSIBLE PARTY/PRIMARY CARD HOLDER:

NAME: ______________________ Relationship to patient: ______________ Phone: __________

Date of Birth: Age: SSN:

Address: ____
(name, street, box, apt, space)

INSURANCE INFORMATION:

Primary Behavioral Health Insurance: ____
Identification No.: ______________________ Group No.: ______________________ Phone: __________
Authorization No.:

I authorize the release of any of my medical, psychiatric or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefits (out-patient mental health benefits) to the physician or supplier for services rendered. I fully understand that if my insurance denies payment for any services defined as a non-covered service, I will be responsible for any amount due. I further understand if my account gets referred to or placed with a collection agency that I will be fully responsible to provide the office the type of plan you have and prior authorization that is needed from your insurance company to cover the costs of your visit before your first and future appointments.

______________________________ ______________________________

Signature Date

DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

GENERAL MEDICAL INFORMATION

Patient Name:

Primary Care Physician Name: Phone #:

Address: Fax #:

Approx. dates of last blood work and physical exam:

Other Physician/therapists: Name:

Name: Specialty: Phone:

Medical History: (do you have any or have you had)

Seizures	Y	N	Chest pain	Y	N	Constipation/diarrhea	Y	N
Epilepsy	Y	N	High Blood Pressure	Y	N	Nausea/vomiting	Y	N
Stroke or TIA	Y	N	Heart palpitations	Y	N	Irritable bowel syndrome	Y	N
Dizziness	Y	N	Heart disease	Y	N	Urinary difficulties	Y	N
Head Injury	Y	N	Bleeding/clotting disorder	Y	N	Energy problems	Y	N
Loss of consciousness	Y	N	Heartburn/acid reflux	Y	N	Sleep problems	Y	N
Frequent Headaches	Y	N	Diabetes	Y	N	Weight changes	Y	N
Memory loss/problems	Y	N	Thyroid disease	Y	N	Night sweats	Y	N
Hearing loss	Y	N	HIV	Y	N	Change in sex drive	Y	N
Tinnitus/ear ringing	Y	N	Hepatitis	Y	N	Skin rashes	Y	N
Chronic pain	Y	N	Asthma	Y	N	Seasonal allergies	Y	N
Arthritis	Y	N	Lung disease	Y	N	Cancer	Y	N
Fibromyalgia	Y	N	High cholesterol/triglycerides	Y	N	Glaucoma/vision problems	Y	N

Other medical issues:

Medications: (including vitamins, supplements, birth control)

Pharmacy: Name: Phone: Address:

History of Surgeries:

For women: Are you currently pregnant? How far along?

History of irregular periods? Are you on birth control?

Do you give permission to share information with the above listed doctors: **YES NO**

Patient Signature	Patient Name	Date

DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

FOR LEANDRA FIFER AND ANNDREA TERRY'S PATIENTS.

Should I be aware of any other problems related to your physical/emotional wellbeing?

____

____

Family members and others living in your household: (name, relationship, age)

____

____

Original Family Members (Mother, father, sisters, brothers, age or deceased)

____

Have you worked with a counselor before? ____________________

When? ________________ What was your experience? ________________

____

What concerns do you have at time? What do you hope to accomplish? ________________

____

____

The things are important to me about my mental/emotional health at this time: ________________

____

____

____

____

DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

Medication Monitoring and Drug Analysis

We are asking that all patients provide a saliva and/or urine sample to be able to monitor your prescribed medications accurately. This is to support medical necessity by establishing a baseline on all patients. This test will make sure we are not giving you a medication that would have a bad reaction to any other medication(s) including illicit drugs that you might be taking. This will also improve patient care and communication by managing the misuse and risk associated with select medications.

If you are being prescribed a controlled medication you will be tested periodically at the doctor's direction. If there are any inconsistent results the doctors may request that you retest at any time for any patient. This test would be $10 if insurance does not cover it.

You may refuse to have this test done, but it will be discussed with the doctor.

I have read and understood the above policy. By signing, I acknowledge that I will adhere and agree to the office policy.

Signature:______________________________________

Printed name:______________________________________

Date:______________________________________

DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

FEE SCHEDULE

The following fees apply to patients paying out of pocket. These treatment fees are kept within the standard of the Tucson community.

Psychiatry Service		Charge	If No Show or late Cancellation	
Initial Diagnostic Evaluation	60min	$325	$150	
Follow up Appointments:	15min	$150	$50	
Phone sessions:	10-15min	$150	$50	_______ Initials

Physiological Services				
Therapy Intake	60min	$100-125	$100-125	
Therapy Session	60min	$65-85	$65-85	Initials

Other Charges:		
Returned check fee	$35	
Late Co-Payment fee	$5	
Overdue Balance per month (30 days past due)	$5 (balance under $100)	
Overdue Balance per month (30 days past due)	$10 (balance over $100)	
Early Refills (see prescription policies)	$10	
Medical (inactive patients) Records storage fee	$25	
FMLA/Disability forms	$35	
Competency Evaluations	$450	_______
Legal Work appearances per hour	$325	Initials

FINANCIAL POLICIES

- **Payment is due and expected at the time of service.** Personal checks, cash, Visa/Master Card are accepted. There is a $35 charge for returned checks.
- **Follow up missed appointments, late cancellations, or changing appointments with less than 24 business hours' notice will result in the patient being responsible for a full fee of the scheduled service** (please refer to the fee scheduled above for further details about fees).
- **New patients missed appointments, late cancellations, or changing appointments with less than 48 business hours' notice will result in the patient being responsible for a full fee of the scheduled service.** (Please refer to the fee scheduled above for further details about fees).
  Please give more than 24 business hours' notice for follow up appointments and 48 business hours for new patient appointments in order to avoid having to pay out of pocket for missed, late cancelled or changed appointments. (Example: if your appointment is Monday at 3:15pm, you **must** cancel before Friday at 3:15pm). If you call and there is no answer, leave a message. The voicemail will timestamp your message.
- I require a $75 deposit for all New Patients appointments this is my office policy and its outside of my insurance contract. Therefore, is an agreement between you and the office. I agree to pay the deposit over the phone prior to scheduling and understand it will go towards my co-pay, co-ins, or deductible whichever applies. If I Late cancel or No show not within the 48 business hours, I understand the deposit is nonrefundable. I am responsible for the remaining No Show/Late cancellation rate. Initials

If you are more than 5 minutes late for your appointment, you might not be seen and need to reschedule in which will result in a No show fee.

_______________________ _______________________

Signature Date

DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

General Information

Dr. Treusch specializes in providing comprehensive mental health care to the Tucson community. She graduated from the University of Arizona Medical School and then completed her residency in Psychiatry at the U of A, as well. It is Dr. Treusch's goal to provide each patient with individualized and comprehensive treatment. She will keep open communication with your primary care provider and other specialist (unless you direct us otherwise).
Tracy Poston P.A. Tracy Poston has been practicing on the field of psychiatry for 12 years. She is a graduate of Midwestern University. She strongly believes in utilizing the synergy of a multidisciplinary treatment team, as appropriate. Over sixteen years of medical practice and twelve years of involvement providing comprehensive Inpatient Psychiatric Treatment to historically underserved populations helps her provide excellent services.
Leandra Fifer MS, MA, CRC, LAC, Director of Psychology. Leandra is dedicated to creating genuine and non-judgmental therapeutic relationships with her patients and committed to helping patients work towards their goals. Her approach is patient-centered and tailored to each person's unique treatment needs. She utilizes CBT (cognitive behavior therapy) techniques, motivating patients to take control and develop important changes.
Anndrea Terry MA, LPC E-RYT. Anndrea is a professional wellness counselor, specializing integrative practices. Her aim is to help clients regain their emotional wellbeing, while providing them with tools to empower their mental and emotional life. Her therapeutic approach weaves conventional psychology with mindfulness, yoga and wellness-based techniques with the goal of motivating clients to reach their goals.

OFFICE HOURS

We will see patients by appointment only. We are available routinely during the hours below. She may see patients by prior arrangement outside the regular hours.

Monday 8:00am to 5:00pm
Tuesday 8:00am to 5:00pm
Wednesday 8:00am to 5:00pm
Thursday 8:00am to 5:00pm
Friday 8:00am to 3:00pm

Saturday appointments will be by special arrangement only.

EMERGENCIES AND URGENT CALLS

If you have a life threating emergency such as suicidal or homicidal thoughts please call911, go to an emergency room, go to the crisis response center, or call the crisis response center's mental health crisis line at 520-622-6000
During Business hours urgent messages can be left with the receptionist who will relay the message to provider. You may also ask the receptionist to attempt to book an appointment for you within the week. For urgent need afterhours, on weekends, or holidays you will have the option of following the voice prompts on the voicemail and leave a verbal message with your phone number. Providers will call you back from a blocked number.

______________________________ ______________________________

Signature Date

DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

Prescription policies

- Before requesting a refill, please check your bottle to see if there are any refills left. Please make sure to call at least 7 days prior to running out of medications. When you call provider's voice mail please provide your name, date of birth, name of medication and your pharmacy number.

- There will be a $10.00 charge for the following:
  Each lost prescription replacement for any medication
  A rewrite for a partially filled prescription
  A refill request when overdue for an appointment
  Rewrite for prescriptions that cannot be transferred

INSURANCE POLICIES

- If insurance card is not provided at the time of the appointment the patient will be responsible for any changes from the appointment. This office will try to bill the insurance once insurance information is provided up to 90 days.

PRIOR AUTHORIZATION POLICIES

- Prior authorization forms are unfortunately time consuming and a charge of $10.00 is necessary for each of your medications if it requires prior authorization.
- Letters of medically necessity if prior authorization is denied are $25.00 per letter that may need to be submitted.

Signature Date

DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

CONSENT TO RELEASE INFORMATION

Name:____________________________ Date of Birth:________________________

I, __________________________ authorize Desert Health Clinic to RELEASE information to the following person(s) or agency:

____

Specific information to be released: Exchange of information helpful for the coordination of care and treatment in regards to the client's mental health.

I give my permission to Desert Health Clinic to OBTAIN information from the following person(s) or agency:

____

Specific information to be released: Exchange of information helpful for the coordination of care and treatment in regards to the client's mental health.

I voluntarily allow the above named person(s) or agencies to disclose information to facilitate my treatment. I understand that this information will not be forwarded to anyone other than those persons participating in my treatment without my written permission. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

This release/request for information is valid for one (1) year.

______________________________ ______________________________

Signature Date

DESERT HEALTH CLINIC

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

Dear Patient,

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

This practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Treusch. We will require a

Release of Information with a wet signature prior to releasing records. Records will be available to be picked up at the office or can be faxed to a secure fax.

4601 E. Fort Lowell Rd.
Tucson, AZ 85712
Phone (520) 396-4413

4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to provider. You must provide us with a reason that supports your request for

   Amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. Contact The U.S. Department of Health and Human Rights, by mail at 200 Independence Ave, S.W. Washington, D.C. 20201 or at HHS.Mail@hhs.gov. The complaint to the Secretary must be filed within 180 days of when the complainant knew or should have known that the act or omission complaint occurred.
   To file a complaint with our practice, contact Dr. Treusch. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the receptionist or provider.

I hereby acknowledge that I have been presented with a copy of provider’s Notice of Privacy Practices.

Signature ____

Date____

Print Name of Patient ____