

Robert D. Schulte, M.D.
Board certified in Child and Adolescent Psychiatry
Board certified in Adult Psychiatry
9590 E. Ironwood Square Drive, Suite 210
Scottsdale, AZ 85258
480.451.3454 Office 480.451.3453 Fax

Private & Confidential - Patient Information

Today's date _____

Patient's Name (Last, Name, Middle Initial) _____

Birth date ____ - ____ - ____ Age ____ Gender: M / F SS# ____ - ____ - ____

Address _____ City _____ State ____ Zip ____

Home Telephone (____) _____ Work Telephone (____) _____

Cell Phone (____) _____ May We Call You At Work? ____ Yes ____ No

Preferred number for reminder calls: _____

Marital Status: ____ Married ____ Single ____ Divorced ____ Widowed ____ Separated ____ # of Years

Name of Spouse/Significant other/Parent/Guardian: _____

Number of Children / Siblings (if a minor): _____

Names & Ages: _____

What Precipitated This Visit? _____

Referred By _____ Phone (____) _____

If the patient is a minor, please fill out the following:

Mother's Name _____ **Home Phone** _____

Work Phone _____ **Cell / Pager** _____

Address _____ **City** _____ **State** ____ **Zip** ____

Father's Name _____ **Home Phone** _____

Work Phone _____ **Cell / Pager** _____

Address _____ City _____ State _____ Zip _____

Person to Contact in Case of Emergency: _____ Relationship _____

Telephone (_____) _____ Other Telephone (_____) _____

Billing /Responsible Party Address (if Different from Address Above):

Name of Responsible Party _____

Address _____ City _____ State _____ Zip _____

Family Physician Address, Phone & Name: _____

Address _____ City _____ State _____ Zip _____

Phone (_____) _____

Insurance Information (NOTE: We gather insurance information solely for the purpose of expediting coverage for your prescriptions. Some carriers require prior authorization to cover certain medications and will require us to fill out and submit forms on your behalf in order to secure approval. We do not accept insurance for services.)

Carrier: _____ Primary Member ID _____

Pt Member ID _____ Group ID _____

- ***All payments are due at the time of service. We provide you with a "superbill," which is a receipt that functions as a claim and can be sent to your insurance company for re-imbusement.***
- ***There is a 24 hour cancellation policy for appointments. The full session fee for the appointment will be charged if not cancelled 24 hrs ahead.***
- ***We do try to make confirmation calls as a courtesy but clinical matters take precedence and we are not always able to call. Please keep track of your own appointments to avoid missed/late cancelled charges.***
- ***Due to scheduling needs of other patients, we are unable to exceed your scheduled time if you are late.***
- ***For prescription refills being called in, please allow 24 hrs. For prescriptions being mailed or picked up, please allow at least 48hrs. Please make sure to allow sufficient time so you do not run out of medications, especially on weekends.***

Please initial. _____

Physician-Patient Agreement

This agreement has been prepared to help Dr. Schulte's patients understand how the business office operates with respect to the physician-patient relationship. Please read all of the information contained in this agreement and indicate your confirmation by signing this document.

Confidentiality Policy

Please see attached Arizona Form.

Reports/Forms Policy

Dr. Schulte reserves the right to decline patient's seeking reports for third party opinions, as well as disability and divorce cases. The practice is focused on treatment and cannot sustain the amounts of additional report writing these cases require. In the event Dr. Schulte is able to accommodate a request for report or filling out forms for third parties, a non-clinical services fee will be charged at regular session rates in 15 minute increments.

Health Insurance Plans

Dr. Schulte elects NOT to participate with any health insurance plan or policy. All visits are strictly fee for service, with no claim filing or pre-authorization/certification courtesies available. Patients may elect to file claims individually. A Super Bill/receipt will be provided at the time of visit, providing the appropriate mechanism for patients to file the claim with the appropriate insurance plan.

Health insurance policies require patients to release all encounter information for any service rendered and claimed against the health care plan. The diagnosis and treatment information required on the claim form is often forwarded by the patient's insurance plan to the **Medical Information Bureau (MIB)**. The patient's health history then becomes available to other insurance companies without the patient's knowledge or consent. Therefore, Dr. Schulte believes that the release of any diagnostic information through the claims filing process may present a potential risk that could be personally damaging to unknowing patients. Therefore, Dr. Schulte wants each patient to be aware of any potential risk of releasing medical information should an inappropriate party have access to the MIB national database.

Medicare Part B Entitlement Policy

This office will gladly treat patients over the age of 65, but we do not participate in the Medicare Part B program. Medicare eligible patients must sign a Waiver of Medicare Part B Entitlement, indicating that services provided in Dr. Schulte's office will not be claimed against the Medicare Part B Program, but instead is the patient's financial responsibility. Current laws require this waiver to be signed by Dr. Schulte and the patient.

Payment Policy & Terms

A \$25.00 fee will be charged for any returned check. Patients who call Dr. Schulte with routine problems or issues, will be charged a fee of \$57.00 for every 15 minutes. The patient agrees to pay all charges, in accordance with the Payment Policy outlined in this agreement. Should Dr. Schulte's office be forced to incur collection charges or legal fees, the patient agrees to pay them in full.

Termination Policy

Dr. Schulte reserves the right to terminate any patient who violates treatment protocol, is generally non-compliant (with respect to treatment protocols or office policies), willfully disregards treatment objectives that could support positive clinical outcomes, or is rude or disrespectful to him or his staff.

Protocol for secure Storage, Transfer, and Access to Client Records on Termination of the Practice

In the event of my terminating my practice, I will notify active clients that they may locate me by calling me directly at a number provided to them by letter or direct verbal communication or by contacting the Arizona State Psychiatric Association or the Arizona State Medical Board, who may contact me directly and convey the request. For reasons of personal privacy I will only provide direct access to current or recent (six months) clients via providing them with telephonic contact numbers. I will maintain a professional telephonic contact number for a period of three to six months, depending on circumstances at the time of closing of my practice. Inactive clients may contact me via the Arizona Psychiatric Association or the Arizona State Medical Board. I will maintain records at 9590 E. Ironwood Square Drive, Suite 210, Scottsdale, AZ 85258.

I will maintain current contact information with the Arizona Psychiatric Association and the Arizona State Medical Board for the period of time required to maintain records.

I will post two notices in the paper (two weeks apart) regarding the close of the practice and information for locating medical records.

I will respond in a timely manner to client requests for copies or access to their medical records. Unless prohibited by illness or temporary travel unavailability I will respond within 30 days or other legally or ethically responsible requirements.

I will dispose of unclaimed records after the current legal and/or legally specified time requirements by destroying records so that no confidential information remains in usable form.

In the event that circumstances require, I will forward record access and responsibility to another professional who will respond to record requests in accordance with legal and professional standards.

In the event that circumstances require, I will forward access and responsibility to another professional who will respond to record requests in accordance with legal and professional standards.

Currently records may be located at 9590 E. Ironwood square Drive, Suite 210, Scottsdale, AZ 85258.

Patient Responsibilities

Each patient is responsible for providing accurate contact information as well as billing information. If telephone numbers and/or addresses change, patients must inform Dr. Schulte's business office. Furthermore, the patient understands that the examination and treatment provided by Dr. Schulte is limited to psychiatric outpatient services. This does not necessarily constitute total or definitive psychiatric care. Further evaluation and treatment may be required in some cases. It is the patient's responsibility to obtain follow up medical care for general health as needed, or when advised to do so by Dr. Schulte. Further, psychiatry is a specialty within the field of medicine and is not meant to be a substitution for primary medical care.

I have read, understand, and accept, the provisions of this agreement, and have no questions about the policies outlined herein. I understand that if I violate any provisions of this agreement, my treatment may be terminated. I understand that this agreement is binding in the State of Arizona and that the provisions are for my protection and for the protection of Dr. Schulte. The original copy of this agreement will become a part of my private medical record.

Signature

Date

Confidential Patient History

Patient: _____

Please provide the following information about your general health and your health history.

Please Circle P for personal health history. Circle F for areas of family history.

- P F ALCOHOL USE/DRUG USE
- P F ALLERGIES: POLLEN, DUST, ANIMALS
- P F ALLERGIES: MEDICATIONS
- P F ASTHMA, BRONCHITIS
- P F ARTHRITIS, GOUT
- P F ANXIETY
- P F EATING DISORDER: ANOREXIA, BULIMIA
- P F BONE/JOINT CONDITION
- P F BACK, NECK, SPINE, DISC PROBLEM OR INJURY
- P F BIRTH DEFECTS/ DEFORMITY
- P F BLOOD DISEASE: ANEMIA, LEUKEMIA
- P F BLOOD VESSEL, CIRCULATION DISORDER
- P F HIV/Aids
- P F BREAST DISEASE
- P F BREAST IMPLANTS (L/R)
- P F BROKEN BONES/ BONE DISEASE
- P F INTESTINAL DISORDERS
- P F CANCER OF ANY TYPE
- P F CONCUSSION/HEAD INJURY
- P F DIABETES
- P F EAR/NOSE/THROAT DISEASE OR INFECTION
- P F EPILEPSY/SEIZURE DISORDER, CONVULSIONS
- P F HYSTERECTOMY
- P F FEMALE ORGAN IRREGULARITY, ABNORMAL PAP, MENSTRUAL
- P F GALLBLADDER
- P F HEART PROBLEM OR CONDITION
- P F HEPATITIS/LIVER DISORDER
- P F HERNIA
- P F HYPERTENSION, BLOOD PRESSURE DISORDER
- P F HORMONAL/THYROID /PITUITARY DISORDER
- P F IMMUNE SYSTEM DISORDER, LUPUS
- P F STOMACH/ COLON/ CROHN'S DISEASE
- P F KIDNEY/URINARY TRACT CONDITION OR INFECTION
- P F LUNG CONDITION OR INFECTION
- P F MALE ORGAN IRREGULARITY OR CONDITION: PROSTATE, IMPOTENCE
- P F NERVOUS SYSTEM CONDITIONS
- P F MENTAL: NERVOUS, DEPRESSION
- P F MIGRAINES/HEADACHES
- P F MUSCLE/TENDON DISORDERS
- P F PROSTHETIC IMPLANT/ ARTIFICIAL LIMBS
- P F RECONSTRUCTIVE/COSMETIC SURGERY
- P F SEXUALLY TRANSMITTED DISEASES
- P F SKIN DISORDERS/LESIONS/CANCER
- P F STEROID USE: PREDNISONE, ANABOLIC
- P F STROKE
- P F TUMORS, CYSTS, POLYPS, GROWTHS
- P F ULCERS, DIGESTIVE DISORDERS
- P F WEIGHT PROBLEMS
- P F OTHER, EXPLAIN _____

Has there been any family psychiatric history?: _____

Current & Past Medications (please indicate by circling past or current med)

C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	

Do you have any medication allergies? Y N if yes, what medications: _____

Please list any other substances you have allergies to, such as foods or over-the-counter medications:

Have you ever been hospitalized? If yes, please state when, where, why: _____

Have you ever had surgery? If yes, please state type of surgery and when, where, why: _____

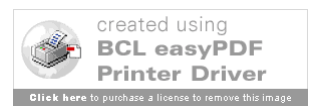
Please check any of the following areas that you have experienced:

[] Head Injury [] Loss of consciousness [] Seizures [] convulsions [] other neurological diagnosis

Have you ever smoked? ___ Yes ___ No If yes, number of years: _____ Daily Use: _____

If female, Date of last menstrual period: _____ Are you pregnant? ___ Yes ___ No

Height: _____ Weight: _____ Blood Pressure History: ___ High ___ Normal ___ Low BP Range (if known): _____



Confidential Patient History Patient:

Please briefly describe your family when you were growing up:

Please list any events from your childhood / or adulthood that have had a profound effect on your life:

Highest grade/Degree completed? Where?
How many hours a week are you employed?
How often do you spend time with others?
How many Children do you have? Do they all live with you?
Describe any areas of conflict with your children and/or spouse:

Please Show history of Substance abuse:

Table with 6 rows and 6 columns. Columns: Substance, Current, Past, Substance, Current, Past. Rows: Alcohol, Tobacco, Caffeine (tea, coffee, Soda), Cocaine, Marijuana, Stimulants, Hypnotics, Diet Pills, Narcotics / Pain, Nerve Pills, Sleeping pills, Others (specify).

Legal History (if applicable):

Have you ever been arrested? Y N
Are you currently or have you ever been involved in a lawsuit?

For Child/adolescent Patient

At what age did problems begin? _____

Does the child get along with siblings? _____

Describe any Difficulties the child has at school: _____

Has the child been held back any grades? Y N Has the child been in special classes? Y N

Has any psychological testing been done at school? _____

Has your child ever been in trouble with the law? if so, please describe: _____

Has your child been in trouble for Drugs or alcohol use? Y N

Did either parent experience similar conditions as children? _____

Besides the above condition has your child ever behaved in a way that seemed especially different or unusual?

Please list persons living in home where child lives:

Name Relationship Age occupation

Developmental

Describe any problems mother had during pregnancy and difficulties during delivery:

Birth Weight: _____ Oxygen: Y N Incubator: Y N Blood Transfusions: Y N

Abnormalities: _____ When were the developmental milestones met?

Verbal _____ Motor _____

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Waiver of Medicare Part B Entitlement

I have voluntarily decided to contract privately for services outside the Medicare Part B program. Neither I, nor my family, nor my heirs, nor my estate shall file any Medicare Part B claims or forms, nor do I require Robert D. Schulte, M.D. or his office staff to do so on my behalf.

I hereby waive my entitlement to Medicare Part B benefits for all services rendered by Robert D. Schulte, M.D.

Medicare Beneficiary Name (Printed)

Medicare ID Number (On Card)

Beneficiary Signature

Date Signed

Robert D. Schulte, M.D.

Date Signed

Robert D. Schulte, M.D.
9590 E. Ironwood Square Dr., Suite 210
Scottsdale, AZ 85258
(P) 480.451.3454 (F) 480.451.3453
Child, Adolescent and Adult Psychiatry

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I, (name of or parent/guardian if a minor) _____, hereby authorize
Dr. Robert Schulte to **obtain information from and release information to:**

Reason for release:

My request Coordination of Care Transfer of Care

Other _____

Patient Name: _____

Patient Date of Birth: _____

Portion of record to be released: other: specify _____

- All _____
 Diagnostic Evaluation _____
 Summary of Contact with Client _____
 Verbal Contact _____
 Diagnostic Test Reports _____

I understand why this information is needed and I am satisfied that it will be held confidential.
Photocopies of this form will be considered as valid as the original. This authorization will remain in
effect until revoked by me in writing or upon termination of care with Dr. Schulte.

Signed _____ Date _____

Witness _____ Date _____

Robert D. Schulte, M.D.

ARIZONA NOTICE FORM

Notice of Psychiatrist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
 - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychiatrist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. “*Psychotherapy Notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- *Incapacitated Adult Domestic Abuse* – If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- *Health Oversight Activities* – If the Arizona Board of Psychiatric Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed

representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychiatrist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

The fee is determined pursuant to Arizona Revised Statute § 12-351-(F)(1), those charges are as follows:

1. Ten cents (\$0.10) per page of standard reproduction of documents
2. Actual cost for reproduction of documents requiring special process
3. Ten dollars (\$10.00) per hour per clerical cost.

Psychiatrist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide a notice to you via mail and require a signature of receipt with an understanding that it is to be returned to my office.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact my office manager, at 480.451.3454.

If you believe that your privacy right has been violated and wish to file a complaint with me/my office, you may send your written complaint to myself or my office manager at:

9590 E. Ironwood Square Dr. Ste. 210
Scottsdale, AZ 85258

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on June 15th, 2003.

Robert D. Schulte, M.D.
9590 E. Ironwood Square Dr., Ste 210
Scottsdale, AZ 85258
480.451.3454 Ph
480.451.3453 Fx

Board Certified in Psychiatry
Board Certified in Child and Adolescent Psychiatry

Acknowledgement of Receipt of Notice of Psychiatrist's Policies and Practices to Protect the Privacy of Your Health Information

I, _____ acknowledge that I have received a copy of Dr. Robert D. Schulte's Notice of Privacy Practices. This Notice describes how Dr. Robert D. Schulte may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of patient or representative

Date

Relationship to patient

Robert Schulte, M.D.
9590 E Ironwood Square D., Suite 210
Scottsdale, AZ 85258
480.451.3454

Our office is located on 96th St. south of Shea Blvd. We are East of the Loop 101, and just south of Shea. Below is a map that shows our office location in relation to the Loop 101.

From the 101-
Head east on Shea to 96th St.
Turn right (south) on to 96th
Turn right on to Ironwood Sq. Dr. (you will pass two turns for the Caremark / CVS campus)
Make your first right into the parking lot and another immediate right will place you in front of 9590 building.

Our office is in the north east corner of the building on the second floor. You can enter the courtyard on either the east or west end of the building. There is one elevator located near the west entry and stairs on both ends.

This map and directions are available on most internet map search engines.

