THE *ALEPH* CENTER, P.L.L.C.

Kevin S. Goeta-Kreisler, M.D.
Christopher Wiegand, M.D
Patty Perea Kane, M.D.
Cynthia Reardon, M.D.
Daniel Fredman, M.D.
Jennifer Andjelich, PMHNP-BC
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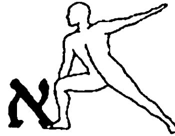

Judith Raymond, Ph.D., L.C.S.W.
Shannon Petrovich, L.C.S.W.
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6408 East Tanque Verde Road
TUCSON, AZ 85715-3809
PHONE: (520) 885-5558 FAX: (520) 885-5559

Confidential

Dear New Patient,

Welcome to my practice! I have been providing outpatient psychiatric care in Tucson for 25 years. After completing my undergraduate and graduate work at Princeton and Yale, I attended medical school and residency at the University of Arizona College of Medicine.

I am in the office Monday through Thursday 8:30 a.m. to 12:30 p.m. My routine practice is to write prescriptions to cover your needs until your next appointment. There should be no need for additional refills if you keep scheduled appointments or reschedule promptly. Please make sure that you schedule or reschedule follow-up appointments so that you do not run out of medication. Before you come to a follow-up appointment, check to see if you will be needing medication refills, so that you can let me know at that appointment.

If an exception occurs, please call the office at least 3 working days before you will run out of medications. I will approve refills during business hours, for active patients with scheduled follow-up appointments. Patients are generally seen at least monthly at first, then up to every two or three months once care is well established. Patients not seen in over three months are not considered active or current patients and will need to schedule an appointment to obtain prescriptions.

Medication changes require appointments so that I can thoroughly discuss new medications with you. If you want to make a medication change please call the office and make an appointment to meet with me. I also maintain a cancellation list.

Due to the additional time and costs incurred, there may be a charge for extended or complex phone calls either to you or on your behalf. If you would like me to complete a report or fill out paperwork on your behalf, first check with the office to see if I can help you. They will also be able to tell you ahead of time what the charges will be.

Looking forward to our ongoing work together,

Patty Perea Kane, MD

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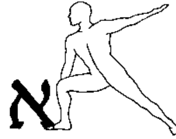

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Welcome, please complete as much of this form as you can. The answers you provide will help us to plan your care. You will only have to fill this form out one time. If you would like a copy let us know and we will be happy to provide one. You may give this form to any other doctors so they can get a better understanding of who you are and how you are affected by your illness. We will fax this form to any provider you designate in the future. Hopefully, you will not have to fill out a form like this again. We will be happy to assist you as needed, Thank you.

Patients Name (Last, First, Middle)	Name you prefer to be called	Date
Family Physician (Name and Phone Number):	Date of Birth	

Why are you coming into the office now?			
Emergency Contact	Relationship of Contact	Home Phone #	Work Phone #
Have you been hospitalized in the last 30 days? o Yes o No			

General History and Habits (Check all items that apply - past and present)

	No	Past	Current	How Long	Amount
Tobacco	o	o	o		
Alcohol	o	o	o		
Caffeine	o	o	o		
Habit forming drugs	o	o	o		

Nutritional History o No Problem

o Weight Gain	Amount	Time Span	o Weight Loss	Amount	Time Span

Allergies **o No Known Allergies**			
Allergic to:			
Drugs/Food	Describe your reaction	Drugs/Food	Describe your reaction

Health History (Check All items that apply - past and present)

Head/Eyes/Ears/Nose/Throat

o Hearing Loss o Right o Left o Glaucoma o Cataracts o Hay Fever/Allergies
o Vision Loss o Right o Left o Nosebleeds o No Problems oOther_______________

Cardiovascular

o High Blood Pressure o Heart Attack o Chest Pain/Angina o Pacemaker, Internal Defibrillator
o Irregular Heart Rhythm/Murmur o Swelling of Ankles o Cardiac Catheterization /Angioplasty
o Circulation Problems o Congestive Heart Failure o No Problems o Other___________________

Endocrine/Other

o Diabetes o Home Glucose Monitoring o Thyroid Disease o Adrenal Disease o Immune Disorder
o Cancer: Type___________ Treatment_________________ o Blood Disorders-Bleeding, Anemia
o No Problems o Other________________

Neurological

o Headaches o Seizures o Faintness/Dizziness o Weakness/Tingling/Numbness Where__________
Stroke: Any Deficit? _______________________o Back Pain o No Problems o Other__________

Gastrointestinal

o Nausea and Vomiting o Heartburn/Indigestion o Ulcers o Loss of Appetite o Colostomy o Diarrhea
o Constipation o Change in Stool o Liver Disease o Hiatal Hernia o Hepatitis o No Problems
o Other_____________

Genitourinary

o Difficult of Painful Urination o Kidney Stones o Frequent Urination o Prostate Problems
o Kidney Disease o Urinary Infection o Last Menstrual Period_________ Pregnant? o Yes o No
o Venereal Disease o No Problems o Other________________

Respiratory

o Shortness of Breath: Is shortness of breath worse at night? o Yes o No o Chronic Cough
o Cold/Sore Throat: greater than 4 a year o Asthma/Bronchitis o Oxygen at home- Flow Rate________
o Tuberculosis o Phlegm, Color__________ o Chronic Lung Disease o Sinus Infection
o No Problems o Other______________

Musculoskeletal

o Rashes/Bruises/Sores Where____________ o Arthritis o Limited Mobility
Have you fallen in the last year? o Yes o No o No Problems o Other_________________________

Prosthesis/Assistive Devices

o Valves o Joints o Eyes o Artificial o Hearing Aides o Dentures/Teeth o Upper o Lower
o Contact Lens o Glasses o Glasses o Walker, Cane, Wheelchair o No Problems o Other

Continuum of Care

Do you live alone? o Yes o No Are others dependent on you for their care? o Yes o No
Do you live in a nursing home, adult care home, or use home health services? o Yes o No
Facility Name:_________________ Phone:___________________ Do you have assistance available for your daily care(Examples: meals, bathing, transportation) o Yes o No
Do you feel safe at home? o Yes o No

Psychosocial History

Do you have an Advanced Directive/Living Will o Yes o No Where is it located? _____________
Do you have a Durable Power of Attorney? o Yes o No If you have either of these documents please bring a copy with you next time.
Are you an Organ Donor? o Yes o No Are there any situations that are causing you stress? o Yes o No
Explain:____
How do you relax?:____
Do you exercise? o Yes o No What and How often? ____
Where do you gain your greatest support? ____
Who helps you with your decisions?____

Do you learn best by: o Reading o Listening o Video o Demonstration o Other:_________________

Patient Medications: please list all the medications you take, include Aspirin, Water Pills, Vitamins, Herbal Supplements, Laxatives, Heart Medicine, Birth Control Pills, ETC.							
Name Of Medication	**Dose(s)**	**Purpose**	**Breakfast**	**Lunch**	**Dinner**	**Bedtime**	**As Needed**

Do you and your family understand you medications and current treatment?
o Clearly o Need more information
What Pharmacy (ies) do you use? ______________________________ Phone #'s:___________________

Family of Origin

As a child who did you live with? Natural, adoptive, step-parents, grandparents and/or in a foster home? List all that apply and explain.

____
____
____

How many brothers and sisters did you have? Number of brothers___ sisters___
Which child were you? _______
Mother: Age___ Age at death_______ Year of death_______
Cause of death____
Quality of Relationship (Past or Present) ____
Father: Age___ Age at death_______ Year of death______
Cause of death____
Quality of Relationship (Past or Present)____
Parents' Relationship____

Brothers/Sisters		
Name	**Alive/Deceased**	**Amount of Contact**

Gender/Identity
o Nonbinary/Gender Fluid o Trans o Cis o Heterosexual o Lesbian/Gay o Other ____________________

Marital/Relationship History					
o Single o Married o Widowed o Divorced o Other______________ Number of Marriages______					
	Age	**Length**	**Termination**	**Children**	**Spouse's Name**
1st Marriage					
2nd Marriage					
3rd Marriage					
4th Marriage					

Describe the relationship of current and/or past marriages.

____

____

Pain History
Do you have pain? o Yes o No o New o Chronic
How do you manage your pain at home?

Children

Name	Age	Alive/Deceased	Amount of Contact	Quality of Relationship Past/Present

Miscarriages, abortions, stillbirths

____

Environment
Do you live in a: o House o Apartment o Nursing Home o Other________________________
Do you: o Rent o Own o Live with relatives
Who are the members of your household?

Financial Summary: (Include resources, stability of resource and ability to live on current income)

____

____

____

____

Peer Relationships/Social Life.

Describe peer relationships, past and present

____
____

Has anyone important to you died or moved away recently? o Yes o No

Who? ____

Describe your social life, past and present

____
____

Club and/or Organization Affiliation, past and present

____
____

Cultural Influences/Spiritual History

Are there any particular cultural influences you feel need to be taken in consideration while you are in treatment?

____
____

Religious Affiliation ____

Present/Past participation in church____

Vocational/Avocational History
Education: Grade completed _______ Trade School/College Attended_____________________________
Current Employment status: o Retired Date_____ o Semi-Retired Date______ o Disabled Date _____ o Employed Full-Time o Employed Part-Time

Are you satisfied with your current employment status?

____
____

Work History

____
____

Hobbies and interests (past and present)

____
____

Military History o Not Applicable

Branch of Service___________________ Rank ____________ Date: From_______ To __________

Assignments

____
____

Wounded in Action? ____

Type of discharge____

Medical History

To your knowledge, was your mother's pregnancy with you abnormal? If abnormal or problems with delivery or soon after your birth, Explain:

____
____

Childhood: Major Illnesses/Injuries/Handicaps/Surgeries

____
____

Psychiatric History
Have you ever participated in individual or group therapy and/or seen a Psychiatrist? o yes o no
Have you ever been treated for any of the following? o Yes o No (If Yes, check all that apply)
o Depression o Anxiety/Panic o Adjustment Problems(s) o Eating Disorder o Chemical Dependency
o Other

If you answered "Yes" to either of the above questions please give the date(s) and indicate treatment effectiveness

____
____
____

Family history of emotional problems

____
____

Drug and Alcohol History

Current Status of alcohol intake (include frequency, amount and date of last use)

____
____

Past history of alcohol intake (include frequency, amount and longest period of abstinence)

____
____

Have you ever cut down your intake of alcohol? o Yes o No
Were people around you ever angered at your drinking? o Yes o No
Have you ever felt guilty about things you've done while drinking? o Yes o No
Have you ever had a drink before noon? o Yes o No
Have you ever sought treatment for alcohol abuse (AA, private counseling, etc.)?

Have you ever used sleeping pills, pain killers, or tranquilizers? o Yes o No Explain: (include frequency, amount, longest period of abstinence, date of last use)

____
____

Have you ever used illegal drugs? o Yes o No
Marijuana o Yes o No LSD or other hallucinogens, mushrooms, peyote o Yes o No
Cocaine o Yes o No Speed o Yes o No Huffing gas, paint, etc. o Yes o No Heroin o Yes o No
I.V. Drugs o Yes o No Explain:

____
____
____

Have you ever-sought treatment for drug abuse? o Yes o No
Has or is anyone in your family attended/ing any other support group o Yes o No

If yes, specify who and what group

____
____

Are you concerned about drinking/drug abuse? o Yes o No   If yes, why?

____
____

What changes about your personality when you drink or use?

____
____

When did you first become concerned and why?

____
____

After Completing this, is there anything else we have not addressed that is important to you?

____
____

____
Patient/Family Signature

____________ ____________
Date Time

THANK YOU FOR CHOOSING US TO HELP YOU.

THE *ALEPH* CENTER, P.L.L.C.

Past medications

Please check any of the medications below that you have taken in the past that you can remember.

Antidepressants				Drug & Alcohol			
☐	Prozac/fluoxetine	☐	Paxil/paroxetine	☐	Naltrexone	☐	Campral/acamprosate
☐	Effexor/venlafaxine &/or Pristiq/desvenlafaxine	☐	Celexa/citalopram &/or Lexapro/escitalopram	☐	Antabuse/disulfuram	☐	Buprenorphine
☐	Cymbalta/duloxetine	☐	Zoloft/sertraline	**Medications for Dementia**			
☐	Luvox/fluvoxamine	☐	Fetzima/milnacipran	☐	Tacrine	☐	Aricept/donepezil
☐	Wellbutrin/bupropion	☐	Remeron/mirtazapine	☐	Exelon/rivastigmine	☐	Razadyne/galantamine
☐	Serzone/nefazodone	☐	Trintellix/vortioxetine	☐	Namenda/memantine		
☐	Viibryd/vilazodone	☐	Ketamine/esketamine				
Tricyclic Antidepressants (TCA's)				**Sleep Aids**			
☐	Anafranil/Clomipramine	☐	Pamelor/Nortiptyline	☐	Desyrel/Trazodone	☐	Benadryl/Diphenhydramine
☐	Elavil/Amitriptyline	☐	Norpramin/Desipramine	☐	L-TRP/Tryptophan	☐	Ambien
☐	Tofranil/Imipramine	☐	Sinequan/Doxepin	☐	Sonata	☐	Chloral Hydrate
☐	Vivactil/Protriptyline	☐	Ludiomil/Maprotiline	☐	Lunesta	☐	Rozerem
MAOI's				☐	Melatonin	☐	Belsomra
☐	Parnate/Tranylcypromine	☐	Nardil/Phenelzine	**Treatment for ADHD**			
☐	Marplan/isocarboxazid	☐	Eldepryl/Selegeline	☐	Ritalin/Concerta	☐	Dexedrine
☐	Emsam Patch/selegiline			☐	Adderall	☐	Strattera
Alternative/Agents				**Mood Stabilizers/Anticonvulsants**			
☐	St. John's Wort	☐	SAM-e	☐	Lithium	☐	Tegretol/Carbamazepine
☐	Omega 3 Fatty Acid	☐	Valerian	☐	Trileptal/oxcarbazapine	☐	Depakote/Valproate
☐	Kava Kava	☐	Gingko	☐	Lamictal/Lamotrigine	☐	Gabitril/Tiagabine
☐	Gingseng			☐	Topamax/Topiramate		
Non-Medications Treatment				**Medications for Sleep Disorders**			
☐	Transcranial Magnetic Stimulation(rTMS)	☐	Vagal Nerve Stimulation (VNS)	☐	Provigil/Nuvigil (modafinil/armodafinil)	☐	Xyrem/Sodium Oxybate
☐	ECT						
Antipsychotics				**Anti Anxiety Agents**			
☐	Risperdal/Risperidone	☐	Zyprexa/Olanzapine	☐	Xanax/Alprazolam	☐	Ativan/Lorazepam
☐	Seroquel/Quetiapine	☐	Clozaril/Clozapine	☐	Klonopin/Clonazepam	☐	Serax/Oxazepam
☐	Geodon/Ziprasidone	☐	Abilify/Aripipazole	☐	Tranxene/Clorazepate	☐	Librium/Chlordiazepoxide
☐	Invega/paliperidone	☐	Fanapt/iloperidone	☐	Valium/Diazepam	☐	Prosom/Estazolam
☐	Latuda/lurasidone	☐	Saphris/asenapine	☐	Dalmane/Flurazepam	☐	Restril/Temazepam
☐	Vraylar/cariprazine	☐	Rexulti/brexpiprazole	☐	Buspar/buspirone	☐	Vistaril/Hydroxyzine
☐	Haldol/Haloperidol	☐	Thorazine	☐	Medical MJ,THC,CBD	☐	Neurontin/Gabapentin
☐	Loxitane/Loxapine	☐	OTHER(S):				

PHQ-9 & GAD-7

	Over the last 2 weeks, on how many days have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score

	Over the last 2 weeks, on how many days have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

GAD7 – Total Score

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THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❍	❍
...you were so irritable that you shouted at people or started fights or arguments?	❍	❍
...you felt much more self-confident than usual?	❍	❍
...you got much less sleep than usual and found you didn't really miss it?	❍	❍
...you were much more talkative or spoke much faster than usual?	❍	❍
...thoughts raced through your head or you couldn't slow your mind down?	❍	❍
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍	❍
...you had much more energy than usual?	❍	❍
...you were much more active or did many more things than usual?	❍	❍
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍	❍
...you were much more interested in sex than usual?	❍	❍
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍	❍
...spending money got you or your family into trouble?	❍	❍
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❍	❍

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem   Minor Problem   Moderate Problem   Serious Problem

	YES	NO
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❍	❍
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❍	❍

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Patient Registration Information

PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

Patient Name:	Home Phone: ( )		Date of Birth / /	Age:
Address:	Gender (birth/biological): Male Female Other		Social Security Number:	
City:	State:	Zip Code:	Marital Status: Single / Married / Widowed Divorced / Remarried / Co-habitating	
Employer:	Occupation:		Work Phone :	
Race:	Religion:		Primary Care Provider:	

RESPONSIBLE PARTY / PRIMARY CARD HOLDER

Name:	Date of Birth: / /	Social Security No:	Relationship:	Home Phone: ( )
Address:	City:		State:	Zip Code:
Employer:	Occupation:	Work Phone: ( )		

NOTIFY IN CASE OF EMERGENCY

Name:	Relation:	Home Phone:	Work Phone:
Address:	City:	State:	Zip:

REFERRED BY

Provider:	Family Member: Father / Mother / Brother / Sister Daughter / Son	Other: Father-In-Law / Mother-In-Law / Brother-In-Law Sister-In-Law / Daughter-In-Law / Son-In-Law Niece / Nephew / Cousin / Friend

INSURANCE INFORMATION

Primary Behavioral Health Insurance Carrier:	Carrier's Phone Number:	Identification No:
Secondary Behavioral Health Insurance Carrier:	Carrier's Phone Number:	Identification No:

Our office provides the service of a courtesy reminder call the day before your appointment. To protect your privacy, please indicate how you would prefer this to be done (please check any of the following):

- ❑ Leave a message at your home phone number.
- ❑ Call you at your work / alternate phone number:________________________________
- ❑ You prefer that staff does not confirm your appointment.

Our office requires that you notify us of a cancellation no later than the business day (before 12:00pm) prior to your scheduled appointment. Failing to do so results in you having to pay a $50.00 late charge if you are seeing a therapist or a $100.00 late charge if you are seeing a physician (Insurance does NOT pay for this). Not receiving a call will NOT excuse a missed appointment.

PLEASE READ AND SIGN:

I authorize the release of any of my medical, psychiatric, or other information necessary to process any claim and provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefit to the physician or supplier for services rendered. I fully understand that if my insurance denies payment for any service defined as a non-covered service, I will be responsible for any amount due.

SIGNED:____ DATE:______/______/_______

The Aleph Center, P.L.L.C.

6408 E. Tanque Verde Rd.
Tucson, AZ 85715-3809
(520) 885-5558 fax (520) 885-5559

To our patients. 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

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

We realize that these laws are complicated, but we must provide you with the following important 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 and notices 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 The Aleph Center.

4. You may ask us 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 The Aleph Center. 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. To file a complaint with our practice, contact Dr. Kevin Goeta-Kreisler, Medical Director. 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.

8. An appointment gives us implicit consent to view your medication history that is provided by your Pharmacy Benefit Manager (PBM), the State of Arizona Prescription Monitoring Program and your pharmacy to help in providing your care.

If you have any questions regarding this notice or our health information privacy policies, please contact any of our office staff.

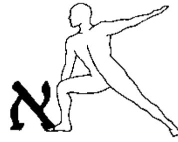
I hereby acknowledge that I have been presented with a copy of The Aleph Center, PLLC's Notice of Privacy Practices.

Signature ____

Date ____

Print Name of Patient ____

THE *ALEPH* CENTER, P.L.L.C.



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GENERAL INFORMATION – **THE *ALEPH* CENTER, P.L.L.C.** is a private organization specializing in the comprehensive care of people with psychiatric disorders including but not limited to geriatrics, anxiety disorders, mood disorders and substance abuse disorders. We keep open communication with your primary care provider and other specialists (unless you direct us otherwise) to provider full service mental health care.

OFFICES – The office is open Monday through Friday 8:00am to 5:00pm. We see patients by appointment only, but may see patients by prior arrangement outside the above hours. However, we are sometimes out of the office seeing hospital and nursing home patients and may not be available all of the above times.

EMERGENCY NUMBER – Our administrative assistants are in the office Monday through Friday 9:00am to 4:30pm to make appointments and take messages. We will return messages before 6:00pm if left prior to 4:30pm. For emergencies, call 911 or go to the nearest emergency room. You may have us paged when prompted. We may take up to 30 minutes to respond.

APPOINTMENTS/CANCELLATIONS/NO SHOWS – We require you to notify the office of a cancellation no later than the business day (24 hours) prior to your appointment. Failing to do so results in you having to pay a **$50.00** late charge if you are seeing a therapist or **$100.00** late charge if you are seeing a physician (Insurance does NOT pay for this). Our office provides a courtesy confirmation call the day before your appointment. **Not receiving a call will NOT excuse a missed appointment**.

Please Initial: ____________________________

PAYMENT IS EXPECTED AT TIME OF VISIT

PAYMENT – Co-Payment is expected at the time of service. We accept most major medical insurers; cash, checks, Visa or Mastercard, and we will bill your insurance carrier for you. However, if payment is not received within 60 days, it becomes your full responsibility.

BALANCES – In excess of 30 days are subject to a monthly service charge of one and one half percent or $5.00, whichever is greater, on the entire balance.

CHARGES

Provider	***Billing Code**	**Fees**
Doctor/NP	90791-90792	$300.00
	90833	$190.00
	90836	$200.00
	90870	$300.00
	99245	$300.00
Therapist/LCSW	90791	$250.00
	90834	$140.00
Court Paperwork/ I and E Exams		$450.00, plus $300 per additional hour.

*** Billing codes are subject to change.**

Please Initial: ___________________________

PATIENT OR RESPONSIBLE PARTY AGREEMENT: I / We have read and do understand the General Information form. I / We agree to the provisions stated herein. I / We consent to the release of appropriate treatment and legal information to the primary care physician, referring doctor or other professional, and the insurance company or any other third party paying for fees. I / We authorize payment of medical benefits directly to THE *ALEPH* CENTER, P.L.L.C.

The provider has reviewed the General Information form with me.

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Date   Signature of Patient or Responsible Party

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Printed name