VALBUENA
360° WELLNESS

PATIENT REGISTRATION FORM

Date: _____

Patient First Name: _____ MI: _____ Last Name: _____
DOB: _____ SS# _____ SEX: _____ M or F
PCP Doctor: _____ PCP Doctor Phone: _____
May we share information with your Primary Care? ___ Y or N
How did you hear about us? _____
Home Phone: _____ Cell Phone: _____ Email: _____
Address: _____City: _____ State & Zip: _____
Responsible Party (if a minor): _____ Relation: _____
In case of Emergency, Notify: _____ Relationship: _____
Home #: _____ Cell #: _____

AUTHORIZED PERSONS TO DISCUSS YOUR ACCOUNT / TREATMENT / MEDICAL RECORDS

Name: _____ Phone: _____ Relation: _____
Name: _____ Phone: _____ Relation: _____
Name: _____ Phone: _____ Relation: _____

☐ I chose NOT to allow any medical or non-medical information to be discussed with anyone.

_____ _____ _____

Signature Printed Name

OFFICE POLICIES

By initialing in the blanks, you acknowledge the following:

Appointments:

_____ I ask that you be on time for your appointments. However, I sometimes run behind schedule because at times patients need more time from me than I had planned for. Please know that I will always extend extra time to you in our sessions if you ever need it. I ask that you be patient and understanding if I am running behind schedule. I will always do my best to alert you ahead of time if I am running more than 30 minutes behind and will always give you the option to reschedule if necessary.

_____ My cancellation policy is as follows: please cancel your appointment by phone or email **no later than 24 hours before your scheduled appointment time**. If you do not cancel your appointment in time, or you do not show up, you will be charged $75 for a no-show fee and $65 for same-day cancellation, no exceptions.

Payment for services:

_____ All balances must be paid prior to scheduling an appointment. This includes billed charges such as those for no shows, late cancellations, prior authorizations, completion of forms and letters, testing, etc. as well as any appointment charges not paid at the time of service.

_____ All patients are required to have a credit card authorization form on file with a valid credit card number included. Credit cards will automatically be charged for appointments that are not cancelled within 24 hours, missed appointments, prescription refills, sent in outside of appointment times, and paperwork fees. We will always notify you prior to charging.

Prescription:

_____ I have a 48-hour window of time to refill any prescriptions. All requests for refills should be made through your pharmacy. I ask that you be mindful of when you are scheduled to run out of medication. Running out of a medication does not constitute an emergency on my part. You are responsible for managing your prescriptions. *A $25 fee* will be charged to your account for prescriptions needing to be refilled outside of appointments due to the time involved in reading through your chart, assessing the appropriateness of the refill, and contacting your pharmacy.

_____ Prescriptions will only be sent in to your pharmacy and refilled Monday – Friday. If you are going to run out of a medication over the weekend, you must inform and send a request to the office by Thursday 3 PM. Prescriptions will not be refilled on holidays or weekends. Medication refills will not be guaranteed on Fridays.

_____ Prescriptions for Schedule II and IV controlled substances (stimulants, benzodiazepenes, sedatives/hypnotics such as Ambien and Lunesta) will never be written for more than 2 months at a time, at which point you are required to come in for an office visit. Prescriptions for Schedule II stimulant medications (Adderall, Adderall XR, Vyvanse, Evekeo, Zenzedi, Ritalin, Concerta) will no longer be written outside of office appointments. If you miss or need to cancel your appointment, you will have to wait until the next available appointment to get a refill on your Schedule II controlled stimulant medication.

_____ I will not refill prescriptions for Schedule II and IV controlled substances earlier than you are scheduled to run out of the prescription, no matter what the reason (lost or stolen prescription, taking more than prescribed, etc.). If you need a dose increase or a change in a controlled substance that I have prescribed for you then you must come in for an office visit. This does not guarantee that I will prescribe an increased dose or frequency of dosing for the controlled substance.

_____Schedule III – Buprenorphine (Suboxone) – We would like to inform you that the $150 paid to VWC is a fee we are charging you that allows you, as patients and clients, special access to VWC for any questions or concerns that you may have to administrative specialists and/or physicians regarding your buprenorphine prescriptions and treatment. Please understand this is a concierge fee on top of any insurance we may have on file.

_____ I will notify VWC, if I receive medication, sleeping pills, tranquilizers, or any other controlled medications from any other doctors. **I understand that I may be dismissed from the practice if I don not notify VWC that I have received controlled medications from another source.**

_____ It is the policy of VWC to randomly request urine drug tests on those patients taking controlled medications. I further understand that if I refuse such a test for any reason, that my provider may not prescribe me the controlled medication.

_____ I give my permission for VWC to contact any pharmacy, physician, or hospital to specifically discuss my medications whenever they feel it is necessary. I understand that providers at VWC also check data on state prescription drug monitoring programs

_____ I actively participate in Arizona's Prescription Monitoring Program and abide by all of its rules and regulations. All patients who receive treatment at this practice will have their controlled substance prescription information looked up in the Prescription Monitoring Program database.

_____ Unless you are an established biannual patient (6 months), If you do not attend an appointment for a period of time in excess of 3 months I will not refill your medications. You will need to be seen in the office for an appointment before any medication can be refilled.

Paperwork:

_____ There will be a fee of a minimum of $35 assessed for any paperwork required from me outside of visit documentation, including but not limited to letters, FMLA paperwork, and any other documentation requiring any portion of my time to fill out.

_____ I <u>DO NOT</u> participate in short-term or long-term disability evaluations. I will not provide any documentation for disability evaluations unless you have been a patient established with this practice for at least one year. At this point I will send copies of your records but will not fill out any additional forms.

Communication:

_____ Any and all communication by email or text between you and me that contains information pertinent to your treatment is considered part of your medical record and will be included in your medical record. This includes communication between me and other individuals (therapist, family member, other healthcare provider, etc.) that you have given me signed permission to communicate with.

Emergency Policy:

_____ If you are experiencing a psychological emergency, a life threatening emergency, and/or medication side effects causing shortness of breath, heart problems, severe rash, or other life threatening concerns, please call 911 or go to your nearest emergency room. It is not guaranteed that I will be available to you outside of normal business hours. Medication management is managed during regular business hours only, when I am in the office.

Client Rights/Discharge:

_____ Non-voluntary discharge from treatment: Just as you have the right to terminate treatment with me at any time, I reserve the right to terminate treatment with any patient if I feel like I am not the right provider for you due to any variety of reasons. You may be terminated via a non-voluntary discharge letter if: (A) you exhibit physical violence, you engage in physical or emotional intimidation, you make threats of any nature, engage in verbal abuse of any kind with me or my staff, and/or you or your family members enter this practice carrying weapons or engage in illegal acts of any kind. Abusive messages or phone correspondence may also be grounds for non-voluntary discharge. (B) You refuse to comply with stipulated practice rules, refuse to comply with treatment plans/recommendations, or do not make a payment and/or payments arrangements in a timely manner. (C) You repeatedly cancel, late cancel, or no show for your appointments.

In the case of non-voluntary discharge from treatment: I will provide you with a list of psychiatrists and psychiatric nurse practitioners in the area that you can receive mental health care from. I will refill your medications for 30 days after the date of termination to ensure continuity of care. After 30 days, you will be discharged from this practice.

_____ _____

Patient Signature Date