4300 North Miller Road
Suite 137
Scottsdale, AZ 85251

Scottsdale Family Psychiatry

Linda Kalivas, M.D.
Kenneth Zwier, M.D.
Kerri Rouse, M.D.
Lance Rouse, M.D.

Dear New Patient:

Enclosed is the "Pre-Appointment Packet". Please fill out the enclosed forms (including the Release of Information forms, (if applicable) and return them to our office as soon as possible. They will be helpful in preparing for the first appointment.

As we discussed on the telephone, we ask that payment be made at the time of your visit as we do not work with insurance companies, including Medicare. We will of course, furnish you with the appropriate paperwork for you to file with your insurance company if you so choose (excluding Medicare, which cannot be billed for our services). In addition, we kindly request a 24-hour cancellation notice so that another patient can be seen during that time. If less than 24-hour is given, you will be charged for the appointment.

If you have any questions, please do not hesitate to contact the office. We look forward to seeing you soon.

Thank You,
The Office

Appointment: _____ _____
Date Time

Please return paperwork no later than _____
Date

Phone: 480.429.8222 Fax: 480.994.7381 Email: scottsdalefamilypsych@outlook.com

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PATIENT REGISTRATION FORM

ADULT PSYCHIATRY

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Emergency Contact: _____ Phone #: _____

I understand that payment is to be made at the end of the time of service, and that 24 hours notice is required for cancellations in order to avoid a charge for the appointment.

_____ _____

Signature of Patient Date

Treatment Consent: I consent to psychiatric consultation/evaluation and treatment for myself, including medication if indicated. If I have questions or concerns, I will discuss them with my physician.

_____ _____

Signature of Patient Date

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Effective 0 1/01/2015

• Please give our staff **48 hours to authorize refills or to complete written prescriptions.** Prescriptions refills will not be done after 5:00 PM on Friday or on Saturday or Sunday. To insure your prescriptions are filled before you run out, please call in advance.

• If you are 15 minutes or more late for your appointment, we reserve the right to reschedule you to another day and/or time. **Missed appointments that have not been cancelled 24 hours in advance are subject to a charge of the full fee.**

• All forms to be filled out by the doctor or the office staff or letters to be written may incur a charge, according to time expended.

• Phone appointments will require pre-payment or a credit card to be kept on file.

In order to give you the best medical care possible, it is your responsibility to inform your doctor of any changes in your medical condition or medications that are prescribed by other physicians.

I have read and understand the above list of policies and procedures.

Printed Name: _____

Signature: _____
(Patient, if over 18, or guradian)

Name of Patient, if different from above: _____

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PATIENT HEALTH QUESTIONAIRE

(PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at All (0)	Several days (1)	More than ½ the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fid ety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yoursel	○	○	○	○

TOTAL (add 0s, 1s, 2s and 3s of the four columns)

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

10. If you checked off any problems, h w difficult have these problems made it for you to do your work, take care of things t home, or get along with other people?

Not difficult t all ○ Very difficult ○ Somewhat difficult ○ Extremely difficu ◉

A2663B 10-04-2005

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Adult ADHD-RS-IV* with Adult Prompts†

The ADHD-RS-IV with Adult Prompts is an 18-item scale based on the DSM-IV-TR" criteria for ADHD that provides a rating of the severity of symptoms. The adult prompts serve as a guide to explore more fully the extent and severity of ADHD symptoms and create a framework to ascertain impairment. The first 9 items assess inattentive symptoms and the last 9 items assess hyperactive-impulsive symptoms. Scoring is based on a 4-point Likert-type severity scale: 0 = none, 1 = mild, 2 = moderate, 3 = severe. Clinicians should score the highest score that is generated for the prompts for each item.

Example: if one prompt generates a "2" and all others are a" 1," by convention, the rating for that item is still a "2" Significant symptoms in clinical trials are generally considered at least a "2" – moderate.

	None (0)	Mild (1)	Moderate (2)	Severe (3)
1. Carelessness Do you make a lot of mistakes (in school or work)? Is this because you're careless? Do you rush through work or activities? Do you have trouble with detailed work? Do you not check your work? Do people complain that you're careless? Are you messy or sloppy? Is your desk or workspace so messy that you have difficulty finding things?	○	○	○	●
2. Difficulty sustaining attention in activities Do you have trouble paying attention when watching movies, reading, or attending lectures? Or on fun activities such as sports or board games? Is it hard for you to keep your mind on school or work? Do you have unusual trouble staying focused on boring or repetitive tasks? Does it take a lot longer than it should to complete tasks because you can't keep your mind on the task? Is it even harder for you than some others you know? Do you have trouble remembering what you read and do you need to re-read the same passage several times?	●	○	○	○
3. Doesn't Listen Do people (spouse, boss, colleagues, friends) complain that you don't seem to listen or respond (or daydream) when spoken to or when asked to do tasks? A lot? Do people have to repeat directions? Do you find that you miss the key parts of conversations because of drifting off in your own thoughts? Does it cause problems?	●	○	○	○
4. No follow through Do you have trouble finishing things (such as work or chores)? Do you often leave things half done and start another project? Do you need consequences (such as deadlines) to finish? Do you have trouble following instructions (especially complex, multistep instructions that have to be done in a certain order with different steps)? Do you need to write down instructions, otherwise you will forget them?	●	○	○	○
5. Can't Organize Do you have trouble organizing tasks into ordered steps? Is it hard prioritizing work and chores? Do you need others to plan for you? Do you have trouble with time management? Does it cause problems? Does difficulty in planning lead to putting off tasks until the last moment possible?	●	○	○	○
6. Avoids/dislikes tasks requiring sustained mental effort Do you avoid tasks (work, chores, reading, board games) that are challenging or lengthy because it's hard to stay focused on these things for a long time? Do you have to force yourself to do these tasks? How hard is it? Do you procrastinate and put off tasks until the last moment possible?	●	○	○	○

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Adult ADHD-RS-IV* with Adult Prompts†

	None (0)	Mild (1)	Moderate (2)	Severe (3)
7. Loses important items Do you lose things (e.g. important work papers, keys, wallet, coats, etc)? A lot? Are you constantly looking for important items? Do you get into trouble for this (at work or at home)? Do you need to put items (e.g. glasses, wallet, keys) in the same place each time, otherwise you will lose them?	○	○	○	○
8. Easily distractible Are you ever very easily distracted by events around you such as noise (conversation, TV, radio), movement, or clutter? Do you need relative isolation to get work done? Can almost anything get your mind off of what you are doing, such as work, chores, or if you're talking to someone? Is it hard to get back to a task once you stop?	○	○	○	○
9. Forgetful in daily activities Do you forget a lot of things in your daily routine? Like what? Chores? Work? Appointments or obligations? Do you forget to bring things to work, such as work materials or assignments due that day? Do you need to write regular reminders to yourself to do most activities or tasks, otherwise you will forget?	○	○	○	○
10. Squirms and Fidgets Can you sit still or are you always moving your hands or feet, or fidgeting with your chair? Do you tap your pencil or your feet? A lot? Do people notice? Do you regularly play with your hair or clothing? Do you consciously resist fidgeting or squirming?	○	○	○	○
11. Can't Stay Seated Do you have trouble staying in your seat? At work? In class? At home (e.g. watching TV, eating dinner)? In church or temple? Do you choose to walk around rather than sit? Do you have to force yourself to remain seated? Is it difficult for you to sit through a long meeting or lecture? Do you try to avoid going to functions that require you to sit still for long periods of time?	○	○	○	○
12. Runs/climbs excessively Are you physically restless? Do you feel restless inside? A lot? Do you feel more agitated when you cannot exercise on an almost daily basis?	○	○	○	○

	None (0)	Mild (1)	Moderate (2)	Severe (3)
13. Can't play/work quietly Do you have a hard time playing/working quietly? During leisure activity (nonstructured times or on your own such as reading a book, listening to music, playing a board game), are you agitated or dysphoric? Do you always need to be busy after work or on vacation?	○	○	○	○
14. On the go, "driven by a motor" Is it hard for you to slow down? Do you feel like you (often) have a lot of energy and that you always have to be moving, are always "on the go"? Do you feel like you're driven by a motor? Do you feel unable to relax?	○	○	○	○
15. Talks excessively Do you talk a lot? All the time? More than other people? Do people complain about your talking? Is it a problem? Are you often louder than the people you're talking to?	○	○	○	○
16. Blurts out answers Do you give answers to questions before someone finishes asking? Do you say things before it is your turn? Do you say things that don't fit into the conversation? Do you do things without thinking? A lot?	○	○	○	○
17. Can't wait for turn Is it hard for you to wait your turn (in converstion, in lines, while driving)? Are you frequently frustrated with delays? Does it cause problems? Do you put a great deal of effort into planning not to be in situations where you might have to wait?	○	○	○	○
18. Intrudes/interrupts others Do you talk when others are talking, without waiting until you are acknowledged? Do you butt into others' conversations before being invited? Do you interrupt others' activities? Is it hard for you to wait to get your point across in conversations or at meetings?	○	○	○	○

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MDQ

Patient Name: _____ Date of Visit: _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and ...	YES	NO
... 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 that you didn't really miss it?	☐	☐
... you were 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 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 in 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?

◯ No problems ◯ Minor problem ◯ Moderate problem ◯ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool. Permission for use granted by RMA Hirschfeld, MD

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CREDIT CARD INFORMATION

I (we), _____ authorize Scottsdale Family Psychiatry, to charge my credit/debit card the amount due for appointments, and/or, phone sessions. This includes fees for any appointments I (we) have failed to keep and have not cancelled or rescheduled 24 hours in advance of the appointment time. I (we) guarantee payment for any services rendered with my (our) credit card. I (we) will also inform the office of any changes in card information and/or expiration date.

_____ _____
Authorized signature of card holder Date

_____ _____
Printed name of card holder Patient name(s) (if different from card holder)

_____ _____ _____
Card Number Exp. Date (MM/YY) CSC/CVV

Card Type:
(please check card type)

- ◯ Visa
- ◯ Mastercard
- ◯ American Express
- ◯ Discover
- ◯ Other _____

Card Billing Address: _____

City: _____ State: _____ Zip Code: _____

For your safety, all credit card information is kept in a locked, safe and secure area of the office. This authorization will stay in effect until I (we) cancel this authorization. To cancel, I (we) must give notification to the office and the account must be in good standing.

PAYMENT IS DUE IN FULL AT TIME OF SERVICE

Scottsdale Family Psychiatry thanks you for your cooperation.

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PHARMACY INFORMATION FORM

Our office can e-scribe your medication prescriptions directly to your pharmacy (some out of state pharmacies are unable to accept our e-scripts for controlled medications). Please enter the pharmacy information, so we can enter it into our database.

PATIENT'S FULL NAME:_____

DATE OF BIRTH: _____

Address: _____

City: _____ State: _____ Zip Code: _____

We can enter up to (3) three pharmacies, if you do have multiple pharmacies please specify which pharmacy to use when calling for your refills. We do ask that 48 hours notification be given for refills. Controlled medications need to be ordered monthly, please be sure to call the office for your refills

Pharmacy #1 _____ Phone #: _____

Address: _____

Pharmacy #2 _____ Phone #: _____

Address: _____

Pharmacy #3 _____ Phone #: _____

Address: _____

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NOTICE: RIGHT TO RECEIVE GOOD FAITH ESTIMATE

The following information is being presented to you due to the new federal law called the "No Surprises Act" which went into effect 1/1/2022. This law requires us to provide you with a "good faith estimate" of the total cost of your treatment. Estimating the total cost of psychiatric and psychotherapy treatment is very difficult because the course of treatment varies for everyone. The law requires us to make this estimate prior to completing an assessment which further complicates things. In psychiatry and psychotherapy, there are only a handful of CPT codes (billing codes) that can be used and the prices for those codes do not vary. Attached you will find a good faith estimate of your treatment.

Under Section 2799B-6 of the Public Health Service Act. health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges. Note: The PHSA and the GFE does not apply currently to any clients who are using insurance benefits. including Out of Network Benefits (seeking reimbursement from your insurance companies)

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care. With my signature, I am saying that I agree to get the items or services from:

Company: Scottsdale Family Psychiatry
Provider: Linda Kalivas, M.D.
Address: 4300 N. Miller Rd., Suite 137, Scottsdale, AZ 85251
NPI: 1518000199 **FEIN:** 82-4877240

Good Faith Estimate

The amount below is only an estimate. It isn't an offer or contract for services. It also does not imply a physician-patient relationship, as the first appointment serves as a consultation only and does not guarantee a treatment agreement. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover for out-of-network providers This means that the final cost of services may be different than this estimate. You and your psychiatrist will determine the frequency of appointments together based on your needs. This may vary depending on whether you receive services for medication management, therapy, or both. Please keep in mind that this estimate does NOT account for any potential out-of-network reimbursement from vour insurance carrier.

The following are our fees for services. Your estimate is being based on the fact that you are scheduled to see a Psychiatrist (M.D.). Should you change providers, please note your fees may increase. This does not account for any potential reimbursement from your insurance carrier.

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CPT Code	Service	Out-Of-Pocket Fee
90792	Initial Psychiatric Consultation	$900.00 Child/Adolescent $600.00 Adult
99213 + 90832	30 minute medication management follow up	$200.00
99214 + 90836	50 minute medication management + psychotherapy follow up	$350.00
Reports, letters, forms	Dependent on the time to complete	$75.00 - $150.00

Common Diagnoses with Dr. Kalivas:

- **Z13.39 Encounter for screening examination for other mental health and behavioral disorders**

Where Services Will Be Received:

- Office (Address: 4300 N. Miller Rd., Suite 137, Scottsdale, AZ 85251)
- Online (secure HIPAA-compllant telehealth platform)

Every client's journey is unique and how long/how often a client may need to engage in therapy and medication management visits can be influenced by several factors:

- Your schedule
- Psychiatrist's availability
- Ongoing life challenges
- Personal finances

Please be aware of the following maximum out-of-pocket scenario: if you meet with Dr. Kalivas 48 weeks per year at the current rate for 50 min each visit, the total cost would be $14,640.00. Not all clients will meet with Dr. Kalivas weekly, and as such, in the collaborative treatment approach, you will discuss your specific needs with Dr. Kalivas. This is an **EXTREME OVERESTIMATION for the vast majority of clients, but this estimate is for you to be aware of the possible out-of-pocket maximum costs over 12 months, should you require that amount of care.** It is based on once-weekly therapy and medication management for a year. The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Disclaimer: This Good Faith Estimate shows the costs of the items and services that are reasonably expected to be for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. Federal law allows you to dispute (appeal) the bill if this happens. If you are billed far more than this Good Faith Estimate, you have the right to dispute the bill.

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You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill or ask if there is financial assistance available.

You may also start a dispute resolution process with the US Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 days (about 4 months) of the date on the original bill. There Is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. lf the Agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process go to www.cms.gov/nosurprises

For questions or information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

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