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 Parents:

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. The first appointment is for the parents and Dr. Zwier alone. The second appointment is for your child and Dr. Zwier alone. The third appointment is for parents and Dr. Zwier alone unless prior arrangements are made with Dr. Zwier.

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 at any time you require a letter or form filled out on your child's behalf, there will be a fee attached.

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 #1: _____ _____
Date Time

Appointment #2: _____ _____
Date Time

Appointment #3: _____ _____
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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CHILD / ADOLESCENT
REGISTRATION FORM

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Responsible Party: _____

Father's Employer: _____ Occupation: _____

Mother's Employer: _____ Occupation: _____

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

_____ _____
Signature of Parent or Guardian (if patient is under 18) Date

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

_____ _____
Signature of Parent or Guardian (if patient is under 18) Date

_____
Relationship to Patient

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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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CHILD / ADOLESCENT
CONTACT SHEET

Mother's Home Phone _____

Mother's Work Phone _____

Mother's Mobile or Pager _____

Father's Home Phone _____

Father's Work Phone _____

Father's Mobile or Pager _____

Mother's Address _____

_____

_____

Father's Address _____

_____

_____

Emergency Contact _____

Emergency Phone _____

Relationship _____

If there are preferences regarding when or who to contact, good days or times, etc., please describe below.

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CHILD / ADOLESCENT

CHILD & FAMILY INFORMATION

Child's name _____ Birthdate _____ Age _____

Address _____ _____ _____ _____
(Street) (City) (State) (Zip)

Home phone _____ Work Phone _____ ☐ Dad ☐ Mom

Child's school _____ Teacher's Name _____

School Address _____ _____ _____ _____
(Street) (City) (State) (Zip)

Is child in special education? ☐ Yes ◯ No If so, what type? _____

Father's name _____ Age _____ Education (years)_____
Father's place of employment _____
Type of employment _____

Mother's name _____ Age _____ Education (years)_____
Mother's place of employment _____
Type of employment _____

Is child adopted? ☐ Yes ◯ No If yes, age when adopted _____
Are parent's married? ☐ Yes ◯ No Separated? ☐ Yes ◯ No Divorced? ☐ Yes ◯ No
Child's physician _____
Physician's address _____ _____ _____ _____
(Street) (City) (State) (Zip)
Physician's telephone number _____
Drug allergies _____
Medications _____

Please list all other children in the family:
Name _____ Age _____ School grade _____
Name _____ Age _____ School grade _____
Name _____ Age _____ School grade _____

Phone: 480.941.3832 Fax: 480.994.7381 Email: scottsdalefamilypsych@outlook.com

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DEVELOPMENTAL AND MEDICAL HISTORY

Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.) _____
Length of delivery (number of hours from initial labor pains to birth) _____
Mother's age when child was born _____
Child's birth weight _____

Did any of the following conditions occur during pregnancy/delivery?	YES	NO
1. Bleeding	☐	○
2. Excessive weight gain (more than 30 pounds)	☐	○
3. Toxemia / Preeclampsia	☐	○
4. Rh factor incompatibility	☐	○
5. Frequent nausea or vomiting	☐	○
6. Serious illness or injury	☐	○
7. Took prescription medications a. If yes, name of medication _____	☐	○
8. Took illegal drugs	☐	○
9. Used alcoholic beverage a. If yes, approximate number of drinks per week _____	☐	○
10. Smoked cigarettes a. If yes, approximate number of cigarettes per day (e.g., 1/2 pack) _____	☐	○
11. Was given medication to ease labor pains If yes, name of medication _____	☐	○
12. Delivery was induced	☐	○
13. Forceps were used during delivery	☐	○
14. Had a breech delivery	☐	○
15. Had a cesarean section delivery	☐	○
16. Other problems - please describe _____	☐	○

Did any of the following conditions affect your child during delivery or within the first few days after birth?	YES	NO
1. Injured during delivery	☐	○
2. Cardiopulmonary distress during delivery	☐	○

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	YES	NO
3. Delivered with cord around neck	☐	○
4. Had trouble breathing following delivery	☐	○
5. Needed oxygen	☐	○
6. Was cyanotic, turned blue	☐	○
7. Was jaundiced, turned yellow	☐	○
8. Had an infection	☐	○
9. Had seizures	☐	○
10. Was given medications	☐	○
11. Born with a congenital defect	☐	○
12. Was in hospital more than 7 days	☐	○

INFANT HEALTH AND TEMPERMENT

During the first 12 months, was your child:

	YES	NO
1. Difficult to feed	☐	○
2. Difficult to get to sleep	☐	○
3. Colicky	☐	○
4. Difficult to put on a schedule	☐	○
5. Alert	☐	○
6. Cheerful	☐	○
7. Affectionate	☐	○
8. Sociable	☐	○
9. Easy to comfort	☐	○
10. Difficult to keep busy	☐	○
11. Overactive, in constant motion	☐	○
12. Very stubborn, challenging	☐	○

EASY DEVELOPMENTAL

At what age did your child first accomplish the following:

1. Sitting without help _____
2. Crawling _____
3. Walking alone without assistance _____
4. Using single words (e.g., “mama,” “dada,” ‘ball,” etc.) _____
5. Putting two or more words together (e.g., “mama up”) _____
6. Bowel training day and night _____
7. Bladder training day and night _____

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HEALTH HISTORY

Date of child's last physical exam: _____

At any time has your child had the following:	NEVER	PAST	PRESENT
1. Asthma	☐	◯	◯
2. Allergies	☐	◯	◯
3. Diabetes, arthritis, or other chronic illness	☐	◯	◯
4. Epilepsy or seizure disorder	☐	◯	◯
5. Head injuries / loss of consciousness	☐	◯	◯
6. Chicken pox or other common childhood illnesses	☐	◯	◯
7. Heart or blood pressure problems	☐	◯	◯
8. High fevers (over 103°)	☐	◯	◯
9. Broken bones	☐	◯	◯
10. Severe cuts requiring stitches	☐	◯	◯
11. Head injury with loss of consciousness	☐	◯	◯
12. Lead poisoning	☐	◯	◯
13. Surgery	☐	◯	◯
14. Lengthy hospitalization	☐	◯	◯
15. Speech or language problems	☐	◯	◯
16. Chronic ear infections	☐	◯	◯
17. Hearing difficulties	☐	◯	◯
18. Eye or vision problems	☐	◯	◯
19. Fine motor/ handwriting problems	☐	◯	◯
20. Gross motor difficulties, clumsiness	☐	◯	◯
21. Appetite problems (overeating or undereating)	☐	◯	◯
22. Sleep problems (falling asleep, staying asleep)	☐	◯	◯
23. Soiling problems	☐	◯	◯
24. Wetting problems	☐	◯	◯
25. Other health difficulties - please describe: _____	☐	◯	◯

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HEALTH HISTORY (CONT.)

Now, please describe in your own words why you want your child to be evaluated at this time:

Any other information which you feel is important:

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VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Child's Name: _____ Date: _____

Date of Birth: _____ Age: _____ Grade: _____

Choose the number on the scale that corresponds to how you would rate your child's behavior.

0 = Never 1 = Occasionally 2 = Often 3 = Very Often

	0	1	2	3
1. Does not pay attention to details or makes careless mistakes, for example homework	○	○	○	○
2. Has difficulty attending to what needs to be done	○	○	○	○
3. Does not seem to listen when spoken to directly	○	○	○	○
4. Does not follow through when given directions and fails to finish things	○	○	○	○
5. Has difficulty organizing tasks and activities	○	○	○	○
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	○	○	○	○
7. Loses things needed for tasks or activities (assignments, pencils, books)	○	○	○	○
8. Is easily distracted by noises or other things	○	○	○	○
9. Is forgetful in daily activities	○	○	○	○
10. Fidgets with hands or feet or squirms in seat	○	○	○	○
11. Leaves seat when he is suppose to stay in his seat	○	○	○	○
12. Runs about or climbs too much when he is suppose to stay seated	○	○	○	○
13. Has difficulty playing or starting quiet games	○	○	○	○
14. Is "on the go" or often acts as if "driven by a motor"	○	○	○	○
15. Talks too much	○	○	○	○
16. Blurts out answers before questions have been completed	○	○	○	○
17. Has difficulty waiting his/her turn	○	○	○	○
18. Interrupts or bothers others when they are talking or playing games	○	○	○	○
19. Argues with adults	○	○	○	○
20. Loses temper	○	○	○	○
21. Actively disobeys or refuses to follow an adults' requests or rules	○	○	○	○
22. Bothers people on purpose	○	○	○	○
23. Blames others for his or her mistakes or misbehaviors	○	○	○	○
24. Is touchy or easily annoyed by others	○	○	○	○
25. Is angry or bitter	○	○	○	○
26. Is hateful and wants to get even	○	○	○	○
27. Bullies, threatens, or scares others	○	○	○	○
28. Starts physical fights	○	○	○	○

From Vanderbilt Children's Hospital Center for Child Development

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VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Child's Name: _____

Choose the number on the scale that corresponds to how you would rate your child's behavior.

0 = Never 1 = Occasionally 2 = Often 3 = Very Often

	0	1	2	3
29. Lies to get out of trouble or to avoid jobs (i.e., "cons" others)	○	○	○	○
30. Skips school without permission	○	○	○	○
31. Is physically unkind to people	○	○	○	○
32. Has stolen things that have value	○	○	○	○
33. Destroys others' property on purpose	○	○	○	○
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	○	○	○	○
35. Is physically mean to animals	○	○	○	○
36. Has set fires on purpose to cause damage	○	○	○	○
37. Has broken into someone else's home, business, or car	○	○	○	○
38. Has stayed out at night without permission	○	○	○	○
39. Has run away from home overnight	○	○	○	○
40. Has forced someone into sexual activity	○	○	○	○
41. Is fearful, nervous, or worried	○	○	○	○
42. Is afraid to try new things for fear of making mistakes	○	○	○	○
43. Feels useless or inferior	○	○	○	○
44. Blames self for problems, feels at fault	○	○	○	○
45. Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	○	○	○	○
46. Is sad or unhappy	○	○	○	○
47. Feels different and easily embarrassed	○	○	○	○

How is your child doing?	Problem 1	2	Average 3	Above Avg 4	5
1. Rate how your child is doing in school overall	○	○	○	○	○
a. How is your child doing in reading?	○	○	○	○	○
b. How is your child doing in writing?	○	○	○	○	○
c. How is your child doing in math?	○	○	○	○	○
2. How does your child get along with you?	○	○	○	○	○
3. How does your child get along with brothers and sisters?	○	○	○	○	○
4. How does your child get along with others his/her own age?	○	○	○	○	○
5. How does your child do in activities such as games or team play?	○	○	○	○	○

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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: Kenneth Zwier, M.D.
Address: 4300 N. Miller Rd., Suite 137, Scottsdale, AZ 85251
NPI: 1326036427 **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	$870.00 Child/Adolescent $450.00 Adult
99213 + 90832	30 minute medication management follow up	$195.00
99214 + 90836	50 minute medication management + psychotherapy follow up	$300.00
Reports, letters, forms	Dependent on the time to complete	$75.00 - $150.00

Common Diagnoses with Dr. Zwier:

- **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. Zwier 48 weeks per year at the current rate for 50 min each visit, the total cost would be $14,400.00. Not all clients will meet with Dr. Zwier weekly, and as such, in the collaborative treatment approach, you will discuss your specific needs with Dr. Zwier. 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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