PREMIER HEALTH & WELLNESS
4835 E. Cactus Rd. Suite #333
Scottsdale, AZ 85254
(P)602-795-9980 (F)602-795-9984

DATE:________________ **(Forms modified 5/15/15 TT)**

Patient Intake/Information Sheet

( ) Sonia Godbole, M.D. ( ) Supriya Nair, D.O. ( ) Shaili Patel, M.D. ( ) Alpa Sanghvi, M.D

LAST NAME____________________FIRST NAME__________________MI____ DOB____________AGE________

MAILING ADDRESS______________________________ APT ____ CITY______________________ STATE_____ZIP_______

PHONE_________________Gender:M(__)F(__)SS#____-___-____ MARITAL STATUS: ______________________

MESSAGES REGARDING APPOINTMENTS MAY BE LEFT ON MY VOICE MAIL/TEXT). _______YES _______NO

GUARANTOR INFORMATION

GUARANTOR NAME__________________________________RELATIONSHIP TO PATIENT________________

MAILING ADDRESS______________________________ APT ____ CITY______________________ STATE_____ ZIP______

PHONE____________________DOB_______GENDER (_)M(_)F SS#____-___-____EMAIL:__________________

RELEASE OF INFORMATION AUTHORIZATION/EMERGENCY CONTACT INFORMATION

I AUTHORIZE Premier Health & Wellness LLC to release clinical and/or billing information to:

EMERGENCY CONTACT NAME_____________________________________PHONE____________RELATIONSHIP TO PATIENT________

PATIENT/GUARDIAN SIGNATURE____

INSURANCE INFORMATION
PLEASE GIVE CARD TO RECEPTIONIST

PRIMARY INSURANCE____ EMPLOYER____________________

NAME OF POLICY HOLDER___________________________________DOB______________SS#__________________

ID#________________________GROUP#__________________INSURANCE COMPANY PHONE__________________

SECONDARY INSURANCE____POLICY HOLDER____________________

ID#_____________________GROUP#___________________INSURANCE COMPANY PHONE____________________

Authorization to pay insurance benefits to physician: I hereby authorize payment directly to Premier Health & Wellness LLC. Authorization to release information: I hereby authorize Premier Health & Wellness LLC to release all medical information needed to process this claim. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for services rendered to the above mentioned patient in the event that my insurance coverage does not pay. In the event of default, I promise to pay any collection costs and reasonable attorney fees, as may be required to collect for services provided to me. I understand that the verbal and written exchange of information may include reference to diagnostic impressions and/or treatment of alcohol/drug use and emotional illness. I understand that my consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon. The information disclosed to the authorized parties is from treatment which confidentiality is protected by Federal Law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations prohibit further disclosure of this information without specific written consent of the person to whom it pertains.

SIGNATURE OF PATIENT OF PATIENT OR PARENT IF MINOR_____________________________________DATE_________

FINANCIAL POLICY

Welcome to Premier Health & Wellness LLC

(Effective April 1, 2015)

YOU WILL BE REQUIRED TO SIGN A NEW FINANCIAL AGREEMENT EVERY 12 MONTHS.

PATIENT NAME:___________________________________**DATE OF BIRTH:**________________________________

Thank you for choosing **Premier Health & Wellness LLC**. We are committed to providing the finest personalized care. Please carefully read and sign the following statement of our office policies prior to your treatment. Feel free to speak to our billing department if you have any questions.

OUR FEES ARE : INITIAL EVAL. $300, FOLLOW UP $150, MED CHECK $100, DOCUMENT REVIEW/PREPARATION $300/HR

INSURANCE: ANY CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLE IS DUE PRIOR TO YOUR VISIT:
You are ultimately responsible for payment of services if your insurance carrier does not pay for any reason. **IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE.** Please present your insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. Current policies in the “ACA” Affordable Care Act may delay payment of your claims due to non-payment of policy premiums by the patient. If your insurance delays, denies or pays and then re-coups the payment of your claims due to non-payment of the policy premium, you will be responsible to pay the claim in full in accordance with our “Financial Policy” guidelines. The patient is responsible for obtaining all necessary information regarding referrals or authorizations. Failure to do so may result in denial or delay of payments.

NO SHOW/LATE CANCELLATION FEE:
If you need to cancel your appointment, please contact our office **at least 24 business hours before** your appointment time. Because of the high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. A $50.00 fee will be assessed for all missed appointments not canceled with **at least 24 hour** advance notice.

BILLING:

As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification and your insurance card. Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.

In order to keep billing costs to a minimum, all co-pays, co-insurance and deductibles are to be paid on the day of the visit without exception. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in. For your convenience, we accept credit and debit cards from Master Card, Visa, AMEX, Discover, cash and check.

FINANCIAL POLICY (CONT.)

Welcome to Premier Health & Wellness LLC

(Effective April 1, 2015)

In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an “out of network provider” for your insurance, the deductibles and co-insurance amounts may be higher. Your insurance policy, not our office, determines the amounts. After your insurance company processes your claims, you will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you. Patient balances are due and payable in full upon receipt of your statement. Accounts which remain unpaid after 30 days will be assessed a late fee of $5.00 per month. Delinquent accounts will be transferred to a collection agency or our attorney after 90 days.

In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for as long as the law provides.

There will be a $25.00 service fee for all returned checks. Any checks returned for any reason must be paid with certified funds (cashier check, money order or cash).

PRESCRIPTION REFILLS:

Please plan ahead for prescription refills. We encourage you to address refills at the time of your office visit. Any changes in medication, new prescription, or mail in prescription problems require an office visit. No prescription refills will be granted on weekends or after hours.

We respect your time and every attempt is made to run on schedule. Therefore, we ask you to arrive on time for your appointment. If you are late, you may be asked to reschedule. If your doctor is running behind due to emergencies and you need to reschedule, please notify the office staff. If you choose to stay, your visit will be given the same consideration.

A TREATMENT AGREEMENT, DISCLOSURE STATEMENT AND A PRIVACY POLICY (HIPAA) AGREEMENT IS AVAILABLE UPON REQUEST AND I UNDERSTAND AND AGREE TO ABIDE BY MY FINANCIAL RESPONSIBILITIES. I UNDERSTAND THAT INFORMATION WILL BE RELEASED TO MY INSURANCE COMPANY, IF NECESSARY, AND ANY CHARGES THAT MY INSURANCE COMPANY WILL NOT COVER I AM RESPONSIBLE FOR.

TO ENABLE MY PHYSICIAN WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:

PLEASE BE AWARE THAT FAX TRANSMISSIONS ARRIVE AT PREMIER HEALTH AND WELLNESS’ OFFICE AND ARE DISTRIBUTED TO THE INDIVIDUAL PROVIDER. CONFIDENTIALITY IS MAINTAINED WITH THESE RECORDS, AS WITH ALL RECORDS IN OUR OFFICE.

Printed name of patient	**Signature of patient/responsible party**	**Date**

Premier Health & Wellness LLC
4835 E. Cactus Road, Suite 333 Scottsdale, AZ 85254
(602) 795-9980
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CONCERNS AND GOALS:

Patient Name:____Date:____________________

PLEASE DESCRIBE WHY YOU HAVE COME IN: ____

____

DESCRIBE GOALS YOU WANT TO ACCOMPLISH BY COMING HERE:

____

____

PLEASE CIRCLE CONCERNS:

CONCENTRATION	FEARS	BOWEL TROUBLE	SELF-ESTEEM
HOPELESSNESS	GUILT	STOMACH TROUBLE	TEMPER
DEPRESSED	SELF-CONTROL	SEXUAL PROBLEM	RELAXATION
HARM TO SELF	HARM TO OTHERS	DRUG USE	FINANCES
SUICIDAL CONCERNS	IMPULSIVITY	ALCOHOL USE	WORK
HIGH ENERGY	HYPERACTIVE	HEADACHES	MOTIVATION
LOW ENERGY	ATTENTION DIFFICULTIES	MEMORY	LEGAL MATTERS
ANGER	SLEEP PROBLEMS	THOUGHTS	TRAUMA
SPIRITUAL CONCERNS	MEANINGLESSNESS	CAREER CHOICES	ABUSE
TEMPER	DREAMS	UNRESOLVED GRIEF	EDUCATION
NERVOUSNESS	NIGHTMARES	MAKING DECISIONS	UNHAPPINESS
ANXIETY	HEALTH PROBLEMS	SHYNESS	PANIC
EATING/FOOD TROUBLE	APPETITE/WEIGHT	CRYING SPELLS	STRESS

HEALTH INFORMATION:

LIST ALL CURRENT MEDICATIONS & DOSES:____

____

LIST ALL CURRENT & PAST HEALTH PROBLEMS: ____

____

ALLERGIES: ____

____

HAVE YOU BEEN HOSPITALIZED DUE TO YOUR MENTAL HEALTH? ______________________________

IF YES PLEASE PROVIDE DATES AND TREATMENT OUTCOME FOR THOSE EVENTS: ________________

LIST PREVIOUS PSYCHIATRISTS YOU HAVE HAD TREATMENT FROM & DATES:

____

LIST PREVIOUS PSYCHIATRIC MEDICATIONS TRIED:

____

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Patient Name____
Date:_____________________

DRUG AND ALCOHOL ASSESSMENT;

ALCOHOL ASSESSMENT:

Frequency of Alcohol use:

_____ Never ______ Less than1 time/month _____ 1-4 times per month _____ 2-3 times per week ______ Daily

Usual Alcohol Consumption:

______ None _______ 1-2 drinks per sitting ______3-4 drinks per sitting ________ 5 or more drinks per sitting

Frequency of use to levels of intoxication:

______ Never ______ less than 1 time/month ______ 1-4 times per month ______ 2-3 times per week ______ Daily

OTHER SUBSTANCE USE ASSESSMENT: (Check Frequency and Duration for each drug used in the last 6 months)

	CURRENT USE	PAST USE	FREQUENCY
Marijuana	_____	_____	________
Sedative	_____	_____	________
Stimulant	_____	_____	________
Cocaine	_____	_____	________
Opiates	_____	_____	________
Inhalants	_____	_____	________
Hallucinogens	_____	_____	________
Prescription Drugs	_____	_____	________
Methamphetamine	_____	_____	________

Caffeine/energy drinks _____ Number of cups per day ______ Tobacco/e-cigarettes____

if cigarettes-number per day _______

LEGAL INFORMATION:

DO YOU HAVE A PROBATION OFFICER OR CASE WORKER?____ IF YES, WHAT IS HIS/HER NAME? ____________

PHONE NUMBER: ________________________ADDRESS: ____

DO YOU HAVE AN ATTORNEY? ___________ IF YES, WHAT IS HIS/HER NAME?
____

PHONE NUMBER: _____________________ADDRESS: ____

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Patient Name____
Date:_________________________________

MARITAL INFORMATION:

MARRIED: ____ DIVORCED: ______ LIVING TOGETHER: _____ SEPARATED: ______ SINGLE: ______ OTHER: ______

IF YOU CHECKED "OTHER" PLEASE EXPLAIN:
____

LIST DATES AND LENGTHS OF ANY PREVIOUS MARRIAGES:
____

FAMILY HISTORY:

LIST THE NAMES, AGES, AND RELATIONSHIP, OF ALL PERSONS LIVING IN YOUR HOME:

____
____
____

LIST THE NAMES, AND AGES OF ANY IMMEDIATE FAMILY MEMBERS THAT ARE NOT LISTED ABOVE

____
____
____
____
____

RELIGOUS INFORMATION:

ARE SPIRITUAL ISSUES OF CONCERN TO YOU ___________YES __________NO

WHAT IS YOUR RELIGIOUS AFFILIATION, IF ANY? ____

Revised 04/28/15

PATIENT SIGNATURE____ **DATE**________________________________