Tom Reichenbacher, MD

6650 N. Oracle Road
Suite 110
Tucson, AZ 85704
Phone (520) 639-8746
Fax (520) 900-7256

PATIENT REGISTRATION FORM

(Please Print Clearly)

Date: _____

Name: _____Nickname:_____Sex:_____

Date of Birth: _____Age:_____SSN:_____

Address: _____
(Number, Street, Box, Apt, Space) (City) (State) (Zip)

Home Phone: _____Work Phone: _____Cell Phone: _____

Email: _____

Emergency Contact: _____Phone:_____Relationship:_____

Employer: _____
(Name) (Occupation) (Address)

Referred By: _____Family Physician: _____

Members of household:
Name: _____Age: _____Relationship to patient: _____
Name: _____Age: _____Relationship to patient: _____
Name: _____Age: _____Relationship to patient: _____
Name: _____Age: _____Relationship to patient: _____

RESPONSIBLE PARTY/PRIMARY CARD HOLDER:

NAME: _____Relationship to patient: _____Phone:_____

Date of birth: _____ Age: _____Social Security No.: _____

Address: _____
(Number, Street, Box, Apt, Space)

Employer: _____Work Phone: _____

INSURANCE INFORMATION:

Primary Behavioral Health Insurance: _____Self Pay: Yes NO

Identification No.: _____Group No.: _____Phone: _____
Authorization No.: _____

I authorize the release of any of my medical, psychiatric or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefits to the physician or supplier for services rendered. I fully understand that if my insurance denies payment for any services defined as a non-covered service, I will be responsible for any amount due. I further understand if my account gets referred to or placed with a collection agency that I will be fully responsible for all fees assessed with collections.

Patient Name (Print): _____

Patient or Parent/Guardian Signature:_____ Date: _____

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GENERAL INFORMATION

Dr. Reichenbacher is a board certified general, as well as child and adolescent psychiatrist and provides comprehensive mental health care. Dr. Reichenbacher treats each child, adolescent, and adult he sees with individualized and comprehensive treatment. He will keep open communication with your primary care provider and other specialist (unless you direct us otherwise).
This is not a group practice or partnership. Please be aware that there exists only an office sharing arrangement and that no partnership exists. Dr. Reichenbacher's clinical practice is fully independent of all persons, agencies, and he is a sole proprietor.

OFFICE HOURS

Monday: 8:00am to 6:00pm
Tuesday: 8:00am to 6pm
Wednesday: 8:00 am to 6:00 pm
Thursday: 8:00 am to 6:00 pm
Friday: 8:00 am to 5:00 pm
Saturday appointments will be by special arrangement only.

EMERGENCIES AND URGENT CALLS

If you have a life-threatening emergency such as suicidal or homicidal thoughts, please call 911, go to an Emergency Room, go to the Crisis Response Center, or call the Crisis Response center's mental health crisis line at 520-622-6000.

During business hours urgent messages can be left with the receptionist who will relay the message to Dr. Reichenbacher. You may also ask the receptionist to attempt to book an appointment for you within the week.

For urgent needs afterhours, on weekends, or holidays you will have the option of following the voice prompts on the voicemail and leave a verbal message with your phone number. Dr. Reichenbacher will be paged and will call you back from a blocked number.

General messages can be left on the voice mail which is checked each morning and returned within 48 business hours.

_____
Patient Name

_____ _____
Patient or Parent/Guardian Signature **Date**

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FEE SCHEDULE

The following fees apply to patients paying out of pocket. These treatment fees are kept within the standard of the Tucson community.

Service	Charge	If No Show or late cancellation
Initial Diagnostic Evaluation 60min	$275	
Medication Management 15min	$125	$50
Psychotherapy (+/- Med Management) 30min	$150	$70
Psychotherapy (+/- Med Management) 45min	$205	$100
Psychotherapy (+/- Med Management) 60min	$215	$100

Phone sessions:	10-15min	$40
	16-25min	$75
	26-30min	$90

Other charges:	
Returned check fee	$35
Late Co-Payment fee	$5
Overdue balance per month (30 days past due)	$5 (balance under $100)
Overdue balance per month (30 days past due)	$10 (balance over $100)
Early refills (see prescription policies)	$30

FINANCIAL POLICIES

- **Payment is due and expected at the time of service**. Personal checks, cash, and Visa/MasterCard are accepted. There is a $35 charge for returned checks.

- **Missed appointments, late cancellations, or changing appointments with less than 24 business hours notice will result in the patient being responsible for a full fee of the scheduled service** (please refer to the fee schedule above for further details about fees).
  Please give more than 24 business hours notice in order to avoid having to pay out of pocket for missed, late cancelled or changed appointments. (Example: if your appointment is Monday at 3:15pm, you must cancel before Friday at 3:15pm). If you call and there is no answer, leave a message. The voicemail will timestamp your message.

- All accounts must be paid off to keep any scheduled appointments, including, but not limited to No Show fees, Late Cancelation Fees, Deductible Balances, Co-Pays and Past Due Balances. If you have a balance and payment is not received before your next scheduled appointment it **will be cancelled.** Special arrangements can be made for Life-threatening Emergencies.

- Delinquent accounts (balances in excess of 30 days) will be subject to a $5 (for balances less than $100) or a $10 (for balances above $100) service charge per month. You further agree that should your account be turned over to a collection agent, you will be responsible for any and all changes incurred as a result of the collection process. If temporary financial problems arise, please contact office billing staff so that an adequate payment plan may be arranged. Valley Billing Services at 520-393-3500.

_____ _____

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PHONE SESSION

- Phone sessions are not covered by insurance, thus payment becomes the patient's responsibility.
  Fees for phone sessions are the following:
  10-15min $40
  16-25min $75
  26-30min $90

PRESCRIPTION POLICIES

- Before requesting a refill, please check your bottle to see if there are any refills left. Please make sure to call at least 7 days prior to running out of medications. When you call Dr. Reichenbacher's voice mail please provide your name, date of birth, name of medication and your pharmacy number.

- There will be a $30.00 charge for the following:
  Each lost prescription replacement for any medication
  A rewrite for a partially filled prescription
  A refill request when overdue for an appointment
  Rewrite for prescriptions that cannot be transferred.
  Rewrite for new prescription not on formulary or too expensive

- It is often helpful to bring all of your prescription bottles with you on your first appointment or early in your treatment to review your medication and what will need to be refilled. I may not be able to refill new medications in between appointments.

- Make sure you inform us of your pharmacy to send prescriptions to at the time of the appointment.

- Also, inform me if you need 90 day supplies of your prescription at the time of your appointment.

- If you need a refill make sure there is not a refill left on your bottle, call at least 7 days prior to running out of medicine and leave your name or patient's name, date of birth, name of medication and pharmacy.

- If the prescription is for a controlled medication please call the pharmacy first as there should be a prescription waiting for you. If you haven't missed or canceled any

appointments I make sure there are medication refills to last until your next appointment.

- I prefer not to be contacted by your pharmacy for refills.
- Please keep in mind my policies you were shown on your first appointment about when I have to charge you for refills.
- I schedule follow-up appointments at a time to allow new medication to be effective and would not expect to make changes in medication or dosage in between appointments.
- Unless previously arranged, I do have to see you every 3 months to continue to refill medication.

Tom Reichenbacher, MD

PRIOR AUTHORIZATION POLICIES

- Prior Authorization forms are unfortunately time consuming and a charge of $10.00 is necessary for each of your medications if it requires a prior authorization.
- Letters of Medically Necessity if Prior Authorization is denied are $25.00 per letter that may need to be submitted.

_____ _____

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Dear Patient,

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

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

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4. You may ask 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 Dr. Reichenbacher. 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 Secretary of the Department of Health and Human Services. Contact the U.S. Department of Health and Human Rights, by mail at 200 Independence Ave, S.W. Washington D.C. 20201 or at HHS.Mail@hhs.gov. The complaint to the Secretary must be filled with 180 days of when the complainant knew or should have known that the act of omission complaint occurred.
   To file a complaint with our practice, contact Dr. Reichenbacher. 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 an disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the receptionist or Dr. Reichenbacher.

I hereby acknowledge that I have been presented with a copy of Dr. Reichenbacher's Notice of Privacy Practices.

Signature_____
Date_____
Print Name of Patient_____

PLEASE KEEP THIS INFORMATION FOR YOUR RECORDS

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