Patient Registration Information Date:_____

PLEASE PROVIDE AS LEGIBLE AS POSSIBLE THE FOLLOWING INFORMATION

Patient Name: _____Date of Birth:_____

Social Security Number:_____ Sex: Male / Female

Street Address:_____

City:_____ State: _____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____ Work Phone:_____

Employer: _____ Occupation: _____

Marital Status:_____ Spouse's Name:_____

Referral Source: _____

Notify In Case of Emergency

Name:_____ Relationship:_____

Street Address:_____

City:_____ State:_____ Zip:_____

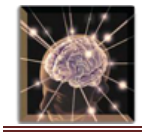
Primary Phone Number: _____ Work Phone:_____

Patients Under 18

I,_____, swear that I am the legal custodial guardian of the child, _____. Unless otherwise specified, NO information, including but not limited to: appointment information, medical records information, or any personal information shall be released to anyone other than the named guardian above.

This information is confidential and will be treated with respect. If at any time you wish to release information to anyone, including yourself, you will be required to sign a written release of information. Please be aware that Arizona law permits non-custodial parents access to their children's mental health and medical records. Please be aware that supplying our facility with false or misleading information is a felonious act and will be treated as such.

Parent/Guardian Signature:_____



MindSource Centre

Responsible Party/Primary Card Holder

Name: _____ Date of Birth:_____

Relationship:_____ Social Security Number:_____

Address:_____

City:_____State:_____Zip:_____

Primary Phone:_____ Work Phone:_____

Insurance Information

Primary Behavioral Health Insurance: _____ Or Self Pay

Identification Number:_____ Group Number:_____

Insurance Provider (Mental Health) Phone Number:_____

Authorization Number (If Applicable):_____

Secondary Behavioral Health Insurance:_____

Identification Number:_____ Group Number:_____

Insurance Provider (Mental Health) Phone Number:_____

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 or mental health benefits to the physician or supplier of services rendered. I fully understand that if my insurance denies payment for any services defined as 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.

Print Name:_____ Date:_____

Sign:_____

Medical History

Patient Name:_____ Date of Birth:_____

Name of Primary Care physician: _____

Medication Allergies:

Any Surgeries (continue on back if necessary):

Have you ever had any of the following? Please circle all that apply

Epilepsy or Seizures
Stroke or TIA
Head Injury
Loss of Consciousness
Glaucoma
Difficulty Hearing
Tinnitus or Chronic Ear Ringing
Frequent Headaches
Heart Attack or Angina
Any Heart Problems
Ankle swelling
High Blood Pressure
Bleeding or Clotting Disorders
Currently on Blood Thinners
Coughing up blood
Asthma
Exposure to Tuberculosis
Lung Disease (other than Asthma)
Allergies
Hepatitis (A, B, C)
GERD or Acid Reflux
Stomach Issues
Irritable Bowel Syndrome (IBS)
Recent Blood in Stool
Recent Dark Black/Tarry Stool
Frequent Constipation
Regular Diarrhea
HIV Positive or AIDS
Cancer (Specify:_____)

High Cholesterol
Diabetes
Thyroid Issues
Changes in Hair Growth Patterns
Heavy Menstrual Periods
Night Sweats
Difficulty Urinating
Incontinence
Blood in Urine
Kidney Disease
Arthritis
Swollen Glands
Skin Rashes
Trouble Sleeping
Dieting
Attempted Suicide (Number of times:_____)
Eating Disorder
Smoke or Nicotine Addiction
Use Illicit Drugs
Alcohol Abuse
Medication Abuse
Pregnant
Sexually Active
Low or High Libido
Difficulty Achieving Orgasm
Difficulty with Arousal/Erections
Date of Last Pap Smear:_____
Date of Last Blood Work:_____

OFFICE POLICIES

Dear Patient,

We welcome you to our working together to assist you with your important concerns and issues. This form will outline our practice's policies in order to optimize your treatment.

We ask that you carefully read, understand and are willing to abide by these office policies. You will be given your signed copy of all policies so you may refer to them as needed. Any questions or issues regarding our policies may be discussed with the office staff or Stephen Streitfeld MD. We value you, our patient, and will continue to provide the best care possible.

Please read:

All appointment reminders will be sent by email only. This is a courtesy only. **You are responsible to remember and keep your appointment regardless if you receive a reminder or not**. We strongly recommend that you register with our Patient Fusion program where you can see your upcoming appointments, medication list, and diagnosis history. In the event of late cancellation or no show, you are responsible for the No Show Fee. The No Show Fee must be paid in full or payment arrangements must be made before another follow up appointment is scheduled. An appointment must be cancelled 48 business hours in advance to avoid the fee. (Example- if your appointment is on Monday at 3:15 pm, you must cancel before Thursday at 3:15pm) More than 3 late cancelations/No Shows in 1 year will result in the termination of care.

Dr Streitfeld will give sufficient prescription refills to cover you until your next scheduled appointment. If you are running out of medication, you should have a follow up appointment coming up. Please contact your pharmacy for any refills you may require. We do not refill medications after office hours, on weekends, or on holidays. Please remind Dr Streitfeld to refill all scripts to your chosen pharmacy at the time of your appointment to prevent lapse in medication. Generally, we do not replace lost prescriptions. Please refer to the Early Refill/Rewrite Policy for details regarding prescriptions.

Prior Authorization Policies

Due to increasing demand and the time consuming necessity to complete the forms we will have to charge $15.00 for each medication if it requires a prior authorization.
Letters of Medically Necessity if a Prior Authorization is denied are $25.00 per letter that may need to be submitted.

Our Staff expects to be treated respectfully at all times. If your behavior at any time is unacceptable we will terminate our treatment relationship and offer to refer you elsewhere. This includes the treatment of other patients in the office and all staff members in or out of the office setting.
We ask that all of our patient over the age of 15 submit to urine and saliva medication level and drug testing so we may accurately monitor your medication levels. We also like this testing to be done to make sure we are not giving you a medication that would have a bad reaction to any other medications you might be taking. This test is not mandatory and you may refuse to have this test done, but the doctor may request it at any time for any patient.

I have read and understand the above policies. By signing, I acknowledge that I will adhere and agree to all office policies. I am willing to continue with my evaluation or treatment.

Printed Name:_____ Date:_____

Signature:_____

Relationship if not patient:_____ Patient's Name:_____

OFFICE POLICIES CONTINUED

Please read:

We are a small office and our staff may not always be available to answer every phone call. Please leave a clear, short message with your name, phone number and a brief reason for your call on our answering machine. Office staff will contact you as soon as possible regarding your call, if necessary. If there is an emergency outside of office hours, call 911 immediately or leave a message with Dr Streitfeld's answering service.

Billing Statement Procedure

If you have a balance you will receive up to two consecutive statements from our office. If we haven't received full payment on your account after two statements have been sent, the account will be sent to a outside collection agency. If your account is sent to a collection agency, you will be given 30 days to select a new physician. During that 30-day period we will continue to provide acute medical care and full payment for services rendered will be due up front. We appreciate your prompt payment on outstanding balances.

Patients under the age of 18 must be accompanied by a parent or legal guardian to each and every appointment. This is required to discuss the minor's condition, issues, progress, and treatment, as well as obtain authorization for treatment plan. If a parent or legal guardian is not present, the appointment will be cancelled and the child will not be seen by Dr Streitfeld. When this occurs, a late cancellation fee will be assessed and must be paid before a follow up appointment will be made. Please refer to the Financial Responsibility Agreement and Policies for more information regarding late cancellations or no shows.

Parents are responsible at all times for their children's behavior in the waiting room, restroom, and office. If a minor's behavior is deemed too disruptive by office staff, they will be asked to leave immediately. Any and all damages to our office will be billed to the parent. The appointment will be cancelled. When this occurs, a late cancellation fee will be assessed and must be paid before a follow up appointment will be made. Please refer to the Financial Responsibility Agreement and Policies for more information regarding late cancellations or no shows.

Occasionally, we do not hear back from a patient or the patient chooses to terminate their care with this practice. If we have not heard from you in over 6 months, we will consider your case closed. At that time, we will close your chart. Should you desire to return to treatment, please contact us. Be aware that if it has been more than 12 months since your last visit, you will be considered a new patient. If you have 3 no show or late cancel appointments in a 1 year time span Dr. Streitfeld may terminate care services with you due to non compliance.

Excessive phone calls to the office or the on call service may incur a fee.

No food or drinks are allowed in the office. No smoking. Our office is a non smoking facility.

No pets are allowed in the office, with the exception of service animals. The owner must provide proper documentation for service animal.

I have read and understand the above policies. By signing, I acknowledge that I will adhere and agree to all office policies. I am willing to continue with my evaluation or treatment.

Printed Name:_____ Date:_____

Signature:_____

Relationship if not patient:_____ Patient's Name:_____

MindSource Centre

SSRI's & Others
Fetzima / I-milnacipran
Brintellix / Vortioxetine
Viibryd / vilzoddone
Prozac / fluoxetine
Paxil / paroxetine
Zolof t / sertaline
Celexa / citalopram
Lexapro / s-citalopram
Luvox / fluvoxamine
Cymbalta / duloxetine
Effexor / venlafaxine
Effexor XR
Pristiq / desvenlafaxine
Wellbutrin / buproprion
Wellbutrin SR / buproprion SR
Wellbutrin XL
Zyban / buproprion
Remeron / mirtazapine
Serzone / nefazodone
Reboxetine (Canada)
Stablon (UK)
Savella / milnacipran
Valdoxan
Vit D3 400-800 IU

ADJUNTIVE & SGA'S
Risperdal / risperidone
Zyprexa / olanzapine
Seroquel / quetiapine
Clozaril / clozapine
Geodone / ziprasidone
Abilify / aripiprazole
Latuda / lurasidone
Fanapt / lloperidone
Saphris

Vitamin E 1600 IU
Amino acids / tarvil

TYPICAL AP'S

ANTI ANXIETY AGENTS
Xanax / alprazolam
Ativan / lorazepam
Klonopin / clonazepam
Serax / oxazepm
Tranxene / clorazepate
Librium / chlordiazepoxide
Valium / diazepam
Other BZD

Theonine

SLEEP AIDS
Desyrel / Trazodone
Ambien / zolpidem
Sonata / zaleplon
Lunesta / eszopiclone
Xyrem / sodium oxybate
Prosom / estazolam
Restoril / temazepam
Dalmane / fluazepam
Somnote / chloral hydrate
Halcion / triazolam
Rozerem / ramelteon
Doral / quazepam
Melatonin
Valerian
Benadryl / diphenhydramine
L-TRP / tryptophan
Hydroxy-TRP

SEXUAL DYSFUNCTION AGENTS
Viagra / sildenafil
Levitra / vardenafil
Cialis / fadalafil
CP Testosterone
1% / androgel / androderm
Dream cream / Reed's pharmacy

TRICYCLIC ANTIDEPRESSANT(TCA'S)
Anafranil / clompramine
Pamelor / nortriptyline
Elavil / amitriptyline
Nopramin / desipramine
Tofranil / Imipramine
Sinequan / doxepin
Vivactil / protriptyline
Ludiomil / maprotyline
Surmontil / Trimipramine

MAOI'S
Parnate / tranylcypramine
Nardil / phenelzine
Marplan / isocarboxazid
Eldepryl / selegiline
EMSAM patch

MOOD STABILIZERS / AED'S
Lithium / Eskalith CR / Lithobid
Equetro / CBZ-ER
Tegretol / carbamazepine
Carbitrol
Trileptol / oxcarbamazepine
Depakote ER
Lamictal / lamotragine
Neurotin / Gabapentin
Lyrica / pregabalin
Topamax / topiramate
Gabitril / tiagabine
Dilantin / phenytoin
Primidone
Mexitil

STIMULANTS, ECT
Vyvanse
Intuniv
Dexedrine / dexroamphetamine
Desoxyn / methamphetamine
Provigil / modafenil
Nuvigil / armodafenil
Ritalin / methylphenidate
Ritalin SR/LA
Daytrana Ritalin patch
Adderal
Adderal XR
Concerta / methylphenidate ER
Cylert
Strattera / atamoxetine
Focalin

AUGMENTERS
Lithium / Eskalith CR / Lithobid
Cytomel / T3
Lamictal / lamotragine
Buspar / lamotragine
Pindolol
Marinol / dronabinol
Folate
Fish oil / omega 3 fatty acids
Vitamin B12

ALTERNATIVE TREATMENTS
St. John's Wort
SAME 400mg BID
Transcranial Magnetic Stimulation
Vagal Nerve Stimulation
ECT
Buprenorphiphine

DRY MOUTH
Urecholine / betanechol
Orajel
Biotene
Pilocarpine / salagen

SWEATING
Clonidine

BRUXISM
Requip
Buspar

Nightmares
Prazosin

DRUG ABUSE TREATMENTS
Campral / acamprosate
Revia / Naltrexone
Antabuse / disulfuram
Suboxone / buprenorphine / naloxone
Subutex / buprenorphone
Chantix / varenicline
Vivitrol / naltrexone

Patient Name:_____ Date:_____

MindSource Centre
7345 E Tanque Verde Rd
Tucson, AZ 85715
Phone: 520-296-7766
Fax: 520-296-2301
Website: www.mindsourcecentre.com

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

An individual release of information must be filled out for each individual or organization that will be releasing or receiving you protected health information. A request for release request may be made in person, by mail, or by fax, unless otherwise stated.

Patient Name: _____ Date of Birth:_____

Social Security Number:_____

The above named patient or legal guardian herby authorized Stephen Streitfeld MD and staff of MindSource Centre to: [ ] Disclose to, [ ] Obtain from, or [ ] Exchange information with:

Person or Organization Name:_____

Address: _____ City_____ State:_____

Phone Number:_____ Fax Number:_____

In addition to the general authorization to release records and health information, I authorize the release of records described as following:

1. [ ] YES [ ] NO Psychiatric/psychological information including diagnosis or treatment.
2. [ ] YES [ ] NO Addiction, substance abuse, or alcohol treatment.
3. [ ] YES [ ] NO Verbal communication between the MindSource Centre & above persons.
4. [ ] YES [ ] NO Sharing of communicable disease information, including records, testing, diagnosis, or treatment of HIV, HIV-related illness, AIDS, and AIDS-related illness.
5. [ ] YES [ ] NO Laboratory results, pathology slides, videotapes, photographs, X-Rays, or other diagnostic imaging results.
6. [ ] YES [ ] NO Billing or financial information.

Disclosure of this information is for the purpose of: [ ] Continuing Care, [ ] Change of Providers,

[ ] Legal Matter, [ ] School, [ ] Employment, [ ] Payment of Services,

[ ] Other:_____

I understand that my records and health information are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFT Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand that this authorization is valid for one (1) year from the date signed and may be revoked by written notification at any time. I understand that I cannot retroactively revoke this authorization for information that has already been released. A photocopy of this authorization may be treated like the original. I understand the protected health information used or disclosed per this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

The release of information will be accepted only if all items have been completed. Release of records or information may be subject to a charge.

_____ _____ _____

Date Signature of Patient or Guardian Witness

NOTICE OF HIPAA PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

This office is required by Federal Regulation, known as the HIPPA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in the Notice.

This office is permitted by Federal privacy laws to make uses and disclosures of your health information for the purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing services to you. The health information about you is documented in written medical record and/or on a computer. Such information may include documenting your symptoms, medical history, examination, test results, diagnoses, treatment, and applying for the future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- A nurse or medical assistant obtains treatment information about you and records it in your health record.
- During the course of treatment, the physician determines he/she will need to consult with another specialist in the area. He/She will share the information with such specialist and obtain his/her input.

Examples of the use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping obtain payment) requests health information from us regarding medical care given. We will provide information to them about you and your care given, which may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to your health insurance company may include information that identifies your diagnoses and the procedures and supplies used.

I acknowledge that I have read and understand this Notice of HIPAA Privacy Policy.

Printed Name:_____ Date:_____

Signature:_____ Relationship if not self:_____

Financial Responsibility Agreement & Policies

This form should clarify the charges associated with MindSource Centre. The fees are based on time duration of service. Session time spent face to face may include interviewing, medication checks, planning, filling out forms, and telephone conversations to other entities.

Please Read the Following:

All appointments must be in the office. Please be aware that insurance companies do not pay for telephone visits, report writing, frequent/lengthy phone contact, late cancellations and/or no show fees. There may be fees assessed with any and all of these services not covered by insurance.

Reports, letters or other paperwork, done while you are not present, may incur a fee. This fee will be based on the amount of time spent on the preparation.

In the event of late cancellation or no show, you are responsible for the No Show Fee. The No Show Fee must be paid in full or payment arrangements must be made before another follow up appointment is scheduled. An appointment must be cancelled 48 business hours in advance to avoid the fee.
Unavoidable circumstances will be taken into consideration and final determination will be made Stephen Streitfeld MD.

In the event that your account gets referred to or placed with our collections agency, you will be fully responsible for all fees assessed with collections and/or any attorney fees or court costs.
All copayments, coinsurance, deductibles and past due amounts are due at time of service, if for any reason you are unable to pay at that time, we will require a signed payment arrangement agreement with a credit or debit card information and the dates we may charge the card. A fee for this convenience may be added to each payment made by this method.

In the event a payment arrangement is not honored, a fee will be assessed and an alternate payment in full will be required before a follow up appointment will be made.

In the event we are not contracted with your insurance company, regardless if it is primary of secondary, you will be responsible for payment. (Example- You have United Healthcare, UHC, as primary and AHCCCS as secondary. Since we are not contracted with AHCCCS, you must pay the copay for UHC. We will not bill an insurance company we are not contracted with.)

I have read and understand the above policies. By signing, I acknowledge that I will adhere and agree to all office policies. I am willing to continue with my evaluation or treatment.

Printed Name:_____Signature:_____

Patient Name:_____ Date: _____

Fee Schedule and Codes

These are some of the basic codes we may bill for at the cash pay prices, if you do not have insurance or your insurance does not cover mental health you will be responsible for these costs to see Dr Streitfeld. All billable codes are not included in this list. If you have any questions, please contact the office for further information.

Initial Evaluation (90792)		$350
Office Visit (99215)	(high complexity up to 40 minutes)	$200
Office Visit (99214)	(moderate complexity up to 25 minutes)	$150
Office Visit (99213)	(low complexity up to 15 minutes)	$125
Transcranial Magnetic Stimulation (TMS) Initial Visit (90867)		$550
Transcranial Magnetic Stimulation (TMS) Follow-up Visit (90868)		$400
Transcranial Magnetic Stimulation (TMS) Threshold Re-eval (90869)		$550
No Show/Late Cancellation Fee (New Patient)		$100
No Show/Late Cancellation Fee		$50
Returned Check Fee		$35
Late Copayment Fee/Broken Payment Arrangement		$5
Under $100 Over 30 Days Past Due Balance Fee PER MONTH		$5
Over $100 Over 30 Days Past Due Balance Fee PER MONTH		$10
Early Refill/Script Rewrite (See Policy)		$10
Medication Prior Authorizations per-medication		$15
Medication Prior Authorization letters		$25

Any questions or issues should be brought to the attention of the office staff or the doctor for review or correction. Stephen Streitfeld MD has the final determination and authority regarding all billing matters.

I have read and understand the above policies. By signing, I acknowledge that I will adhere and agree to all office policies. I am willing to continue with my evaluation or treatment.

Printed Name:_____ Signature:_____

Patient Name:_____ Date: _____