THE *ALEPH* CENTER, P.L.L.C.

6408 East Tanque Verde Road
TUCSON, AZ 85715-3809
PHONE: (520) 885-5558 FAX: (520) 885-5559

GENERAL INFORMATION – THE *ALEPH* CENTER, P.L.L.C. is a private organization specializing in the comprehensive care of people with psychiatric disorders including but not limited to geriatrics, anxiety disorders, mood disorders and substance abuse disorders. We keep open communication with your primary care provider and other specialists (unless you direct us otherwise) to provider full service mental health care.

OFFICES – The office is open Monday through Friday 8:00am to 5:00pm. We see patients by appointment only, but may see patients by prior arrangement outside the above hours. However, we are sometimes out of the office seeing hospital and nursing home patients and may not be available all of the above times.

EMERGENCY NUMBER – Our administrative assistants are in the office Monday through Friday 9:00am to 4:30pm to make appointments and take messages. We will return messages before 6:00pm if left prior to 4:30pm. For emergencies, call 911 or go to the nearest emergency room. You may have us paged when prompted. We may take up to 30 minutes to respond.

APPOINTMENTS/CANCELLATIONS/NO SHOWS – We require you to notify the office of a cancellation no later than the business day (24 hours) prior to your appointment. Failing to do so results in you having to pay a $50.00 late charge if you are seeing a therapist or $100.00 late charge if you are seeing a physician (Insurance does NOT pay for this). Our office provides a courtesy confirmation call the day before your appointment. **Not receiving a call will NOT excuse a missed appointment**. **Initial: _____**

PAYMENT IS EXPECTED AT TIME OF VISIT**

PAYMENT – Co-Payment is expected at the time of service. We accept most major medical insurers; cash, checks, Visa or Mastercard, and we will bill your insurance carrier for you. However, if payment is not received within 60 days, it becomes your full responsibility.

BALANCES – In excess of 30 days are subject to a monthly service charge of one and one half percent or $5.00, whichever is greater, on the entire balance.

CHARGES –

Provider	***Billing Code**	**Fees**
Doctor/NP	90791-90792	$300.00
	90833	$190.00
	90836	$200.00
	90870	$300.00
	99245	$300.00
Therapist/LCSW	90791	$250.00
	90834	$140.00
Court Paperwork/ I and E Exams		$450.00, plus $300 per additional hours.

*** Billing codes are subject to change.**

Initial: _____

PATIENT OR RESPONSIBLE PARTY AGREEMENT: I / We have read and do understand the General Information form. I / We agree to the provisions stated herein.
I / We consent to the release of appropriate treatment and legal information to the primary care physician, referring doctor or other professional, and the insurance company or any other third party paying for fees. I / We authorize payment of medical benefits directly to THE *ALEPH* CENTER, P.L.L.C.

The provider has reviewed the General Information form with me.

_____ _____

Date Signature of Patient or Responsible Party

You are ____ or are not ____ giving us consent to view your medication history that has been provided by your Pharmacy Benefit Manager (PBM), Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), and your Pharmacy to help in providing your care.

Initial: _____

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Welcome, please complete as much of this form as you can. The answers you provide will help us to plan your care. You will only have to fill this form out one time. If you would like a copy let us know and we will be happy to provide one. You may give this form to any other doctors so they can get a better understanding of who you are and how you are affected by your illness. We will fax this form to any provider you designate in the future. Hopefully, you will not have to fill out a form like this again. We will be happy to assist you as needed. Thank you.

Patients Name (Last, First, Middle)	Name you prefer to be called	Date
Family Physician (Name and Phone Number):	Date of Birth	

Why are you coming into the office now?			
Emergency Contact	Relationship of Contact	Home Phone #	Work Phone #
Have you been hospitalized in the last 30 days? o Yes o No			

General History and Habits (Check all items that apply - past and present)

	No	Past	Current	How Long	Amount
Tobacco	o	o	o		
Alcohol	o	o	o		
Caffeine	o	o	o		
Habit forming drugs	o	o	o		

Nutritional History o No Problem

o Weight Gain	Amount	Time Span	o Weight Loss	Amount	Time Span

Allergies o No Known Allergies

Allergic to:

Drugs/Food	Describe your reaction	Drugs/Food	Describe your reaction

Health History (Check All items that apply - past and present)

Head/Eyes/Ears/Nose/Throat

o Hearing Loss o Right o Left o Glaucoma o Cataracts o Hay Fever/Allergies
o Vision Loss o Right o Left o Nosebleeds o No Problems oOther_____

Cardiovascular

o High Blood Pressure o Heart Attack o Chest Pain/Angina o Pacemaker, Internal Defibrillator
o Irregular Heart Rhythm/Murmur o Swelling of Ankles o Cardiac Catheterization /Angioplasty
o Circulation Problems o Congestive Heart Failure o No Problems o Other_____

Endocrine/Other

o Diabetes o Home Glucose Monitoring o Thyroid Disease o Adrenal Disease o Immune Disorder
o Cancer: Type_____ Treatment_____ o Blood Disorders-Bleeding, Anemia
o No Problems o Other_____

Neurological

o Headaches o Seizures o Faintness/Dizziness o Weakness/Tingling/Numbness Where_____
Stroke: Any Deficit? _____o Back Pain o No Problems o Other_____

Gastrointestinal

o Nausea and Vomiting o Heartburn/Indigestion o Ulcers o Loss of Appetite o Colostomy o Diarrhea
o Constipation o Change in Stool o Liver Disease o Hiatal Hernia o Hepatitis o No Problems
o Other_____

Genitourinary

o Difficult of Painful Urination o Kidney Stones o Frequent Urination o Prostate Problems
o Kidney Disease o Urinary Infection o Last Menstrual Period_____ Pregnant? o Yes o No
o Venereal Disease o No Problems o Other_____

Respiratory

o Shortness of Breath: Is shortness of breath worse at night? o Yes o No o Chronic Cough
o Cold/Sore Throat: greater than 4 a year o Asthma/Bronchitis o Oxygen at home- Flow Rate_____
o Tuberculosis o Phlegm, Color_____ o Chronic Lung Disease o Sinus Infection
o No Problems o Other_____

Musculoskeletal

o Rashes/Bruises/Sores Where_____ o Arthritis o Limited Mobility
Have you fallen in the last year? o Yes o No o No Problems o Other_____

Prosthesis/Assistive Devices

o Valves o Joints o Eyes o Artificial o Hearing Aides o Dentures/Teeth o Upper o Lower
o Contact Lens o Glasses o Glasses o Walker, Cane, Wheelchair o No Problems o Other

Continuum of Care

Do you live alone? o Yes o No Are others dependent on you for their care? o Yes o No
Do you live in a nursing home, adult care home, or use home health services? o Yes o No
Facility Name:_____ Phone:_____ Do you have assistance available for your daily care(Examples: meals, bathing, transportation) o Yes o No
Do you feel safe at home? o Yes o No

Psychosocial History

Do you have an Advanced Directive/Living Will o Yes o No Where is it located? _____
Do you have a Durable Power of Attorney? o Yes o No If you have either of these documents please bring a copy with you next time.
Are you an Organ Donor? o Yes o No Are there any situations that are causing you stress? o Yes o No
Explain:_____
How do you relax?:_____
Do you excersize? o Yes o No What and How often?:_____
Where do you gain your greatest support?:_____

Who helps you with your decisions?:_____
Do you learn best by: o Reading o Listening o Video o Demonstration o Other:_____

Patient Medications: please list all the medications you take, include Aspirin, Water Pills, Vitamins, Herbal Supplements, Laxatives, Heart Medicine, Birth Control Pills, ETC.							
Name Of Medication	**Dose(s)**	**Purpose**	**Breakfast**	**Lunch**	**Dinner**	**Bedtime**	**As Needed**

Do you and your family understand you medications and current treatment?
o Clearly o Need more information
What Pharmacy(ies) do you use? _____ Phone #'s:_____

Family Of Origin

As a child who did you live with? Natural, adoptive, step-parents, grandparents and/or in a foster home? List all that apply and explain.

_____
_____
_____

How many brothers and sisters did you have? Number of brothers___ sisters___
Which child were you? _____
Mother: Age___ Age at death_____ Year of death_____
Cause of death_____
Quality of Relationship (Past or Present)_____
Father: Age___ Age at death_____ Year of death_____
Cause of death_____
Quality of Relationship (Past or Present)_____
Parents' Relationship_____

Brothers/Sisters		
Name	**Alive/Deceased**	**Amount of Contact**

Marital/Relationship History					
Sexual Orientation: o Heterosexual o Homosexual o Bisexual o Transgender o Asexual					
o Single o Married o Widowed o Divorced Other_____ Number of Marriages_____					
	Age	**Length**	**Termination**	**Children**	**Spouse's Name**
1st Marriage					
2nd Marriage					
3rd Marriage					
4th Marriage					

Describe the relationship of current and/or past marriages.

_____

_____

_____

Pain History
Do you have pain? o Yes o No o New o Chronic
How do you manage your pain at home?

Children

Name	Age	Alive/Deceased	Amount of Contact	Quality of Relationship Past/Present

Miscarriages, abortions, stillbirths

_____

Environment
Do you live in a: o House o Apartment o Nursing Home o Other_____
Do you: o Rent o Own o Live with relatives
Who are the members of your household?

Financial Summary: (Include resources, stability of resource and ability to live on current income)

_____

_____

Peer Relationships/Social Life.

Describe peer relationships, past and present

_____
_____

Has anyone important to you died or moved away recently? o Yes o No
Who?_____
Describe your social life, past and present

_____
_____

Club and/or Organization Affiliation, past and present

_____
_____

Cultural Influences/Spiritual History

Are there any particular cultural influences you feel need to be taken in consideration while you are in treatment?

_____
_____

Religious Affiliation _____
Present/Past participation in church_____

Vocational/Avocational History
Education: Grade completed _____ Trade School/College Attended_____
Current Employment status: o Retired Date_____ o Semi-Retired Date_____ o Disabled Date _____ o Employed Full-Time o Employed Part-Time

Are you satisfied with your current employment status?

_____
_____

Work History

_____
_____

Hobbies and interests (past and present)

_____
_____

Military History o Not Applicable

Branch of Service_____ Rank _____ Date: From_____ To _____
Assignments

_____
_____

Wounded in Action? _____
Type of discharge_____

Medical History

To your knowledge, was your mother's pregnancy with you abnormal? If abnormal or problems with delivery or soon after your birth, Explain:

_____
_____

Childhood: Major Illnesses/Injuries/Handicaps/Surgeries

_____
_____

Psychiatric History
Have you ever participated in individual or group therapy and/or seen a Psychiatrist? o yes o no
Have you ever been treated for any of the following? o Yes o No (If Yes, check all that apply)
o Depression o Anxiety/Panic o Adjustment Problems(s) o Eating Disorder o Chemical Dependency
o Other

If you answered "Yes" to either of the above questions please give the date(s) and indicate treatment effectiveness

_____
_____
_____

Family history of emotional problems

_____
_____

Drug and Alcohol History

Current Status of alcohol intake (include frequency, amount and date of last use)

_____
_____

Past history of alcohol intake (include frequency, amount and longest period of abstinence)

_____
_____

Have you ever cut down your intake of alcohol? o Yes o No
Were people around you ever angered at your drinking? o Yes o No
Have you ever felt guilty about things you've done while drinking? o Yes o No
Have you ever had a drink before noon? o Yes o No
Have you ever sought treatment for alcohol abuse (AA, private counseling, etc.)?

Have you ever used sleeping pills, pain killers, or tranquilizers? o Yes o No Explain: (include frequency, amount, longest period of abstinence, date of last use)

_____
_____

Have you ever used illegal drugs? o Yes o No
Marijuana o Yes o No LSD or other hallucinogens, mushrooms, peyote o Yes o No
Cocaine o Yes o No Speed o Yes o No Huffing gas, paint, etc. o Yes o No Heroin o Yes o No
I.V. Drugs o Yes o No Explain:

_____
_____
_____

Have you ever-sought treatment for drug abuse? o Yes o No

Has or is anyone in your family attended/ing any other support group o Yes o No
If yes, specify who and what group

_____
_____

Are you concerned about drinking/drug abuse? o Yes o No If yes, why?

_____
_____

What changes about your personality when you drink or use?

_____
_____

When did you first become concerned and why?

_____
_____

After Completing this, is there anything else we have not addressed that is important to you?

_____
_____

_____
Patient/Family Signature

_____
Date

THANK YOU FOR CHOOSING US TO HELP YOU.

THE *ALEPH* CENTER,P.L.L.C.

Name: _____

Please mark any medications you are currently on or are have taken in the past that you can remember.

Antidepressants
Prozac/fluoxetine
Paxil/paroxetine
Zoloft/sertaline
Celexa/citalopram
Cymbalta/duloxetine
Lexapro/escitalopram
Luvox/fluvoxamine
Effexor/venlafaxine
Wellbutrin/bupropion
Remeron/mirtazapine
Serzone/nefazodone
Brintellix/vortioxetine
Viibrid/vilazidone
Fetzima/levomilnacipran

Tricyclic Antidepressants (TCA's)
Anafranil/clomipramine
Pamelor/nortiptyline
Elavil/amitriptyline
Norpramin/desipramine
Tofranil/imipramine
Sinequan/doxepin
Vivactil/protriptyline
Ludiomil/maprotiline

MAOI's
Parnate/tranylcypromine
Nardil/phenelzine
Marplan/isocarboxazid
Eldepryl/selegeline

Alternative Agents
St. John's Wort
SAM-e
Omega 3 Fatty Acid
Valerian
Kava Kava
Gingko
Gingseng

Non-Medication Treatment
Transcranial Magnetic Stimulation (rTMS)
Vagal Nerve Stimulation (VNS)
ECT

Antipsychotic
Risperdal/risperidone
Zyprexa/olanzapine
Seroquel/quetiapine
Clozaril/clozapine
Geodon/ziprasidone
Abilify/aripiprazole
Fanapt/iloperidone
Invega/paliperidone
Saphris/asenapine
Latuda/lurasidone
Long-Acting Injection
Haldol/haloperidol
Prolixin/fluphenazine
Thorazine/chlorpromazine
Mellaril/thioridazine
Trilafon/perphenazine
Loxitane/loxapine
Navane/thiothixine

Drug and Alcohol
Naltrexone

Campral/acamprosate
Antabuse/disulfuram
Suboxone/Buprenorphine
clonidine

Sleep Aids
Desyrel/trazadone
Benadryl/diphenhydramine
L-TRP/tryptophan
Ambien/zolpidem
Sonata/zaleplon
Chloral hydrate
Lunesta/eszopiclone
Rozerem/ramelteon
Melatonin
Belsomra/suvorexant
prazosin

Mood Stabilizers
Lithium
Tegretol/carbamazepine
Trileptal
Depakote/valproate
Lamictal/lamotrigine
Neurontin/gabapentin
Topamax/topiramate
Gabitril/tiagabine
Zonegran

Anti Anxiety Agents
Xanax/alprazolam
Ativan/lorazepam
Klonopin/clonazepam
Serax/oxazepam
Tranxene/clorazepate
Librium/chlordiazepoxide
Valium/diazepam
Prosom/estazolam
Dalmane/flurazepam
Restoril/temazepam

Buspar
Vistaril/hydroxyzine

Treatment for ADHD
Ritalin/Concerta
Dexedrine
Adderall/mixed amphetamine salts
Strattera/atomoxetine
Tenex/guanfacine

Medication for Sleep Disorder
Provigil/modafenil
Nuvigil/armodafenil
Xyrem/sodium oxybate

Medication for Dementia
Tacrine
Aricept (donepezil)
Exelon (Rivastigmine)
Razadyne (Galantamine)
Namenda (memantine)

ALEPH Patient Registration Information

PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

Patient Name:	Home Phone: ( )	Date of Birth / /	Age:
Address:	Gender:	Social Security Number:	
City:	State:	Zip Code:	Marital Status: Single / Married / Widowed Divorced / Remarried / Co-habitating
Employer:	Occupation:	Work Phone :	
Race:	Religion:	Primary Care Provider:	

RESPONSIBLE PARTY / PRIMARY CARD HOLDER

Name:	Date of Birth: / /	Social Security No:	Relationship:	Home Phone: ( )
Address:	City:	State:		Zip Code:
Employer:	Occupation:	Work Phone: ( )		

NOTIFY IN CASE OF EMERGENCY

Name:	Relation:	Home Phone:	Work Phone:
Address:	City:	State:	Zip:

REFERRED BY

Provider:	Family Member: Father / Mother / Brother / Sister Daughter / Son	Other: Father-In-Law / Mother-In-Law / Brother-In-Law Sister-In-Law / Daughter-In-Law / Son-In-Law Niece / Nephew / Cousin / Friend

INSURANCE INFORMATION

Primary Behavioral Health Insurance Carrier:	Carrier's Phone Number:	Identification No:
Secondary Behavioral Health Insurance Carrier:	Carrier's Phone Number:	Identification No:

Our office provides the service of a courtesy reminder call the day before your appointment. To protect your privacy, please indicate how you would prefer this to be done (please check any of the following):

- ❑ Leave a message at your home phone number.
- ❑ Call you at your work / alternate phone number:_____
- ❑ You prefer that staff does not confirm your appointment.

Our office requires that you notify us of a cancellation no later than the business day (before 12:00pm) prior to your scheduled appointment. Failing to do so results in you having to pay a $50.00 late charge if you are seeing a therapist or a $100.00 late charge if you are seeing a physician (Insurance does NOT pay for this). Not receiving a call will NOT excuse a missed appointment.

PLEASE READ AND SIGN:

I authorize the release of any of my medical, psychiatric, or other information necessary to process any claim and provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefit to the physician or supplier for services rendered. I fully understand that if my insurance denies payment for any service defined as a non-covered service, I will be responsible for any amount due.

SIGNED:_____ DATE:_____/_____/_____

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To our patients. 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

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

We realize that these laws are complicated, but we must provide you with the following important 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 a 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 health information to only certain individuals involved in your care or the payment for your care, such as 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 The Aleph Center.

4. You may ask us 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 The Aleph Center. 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 the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Kevin Goeta-Kreisler, Medical Director. 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 and 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 any of our office staff.

I hereby acknowledge that I have been presented with a copy of (name of practice's) Notice of Privacy Practices.

SIGN AND DATE

Signature _____

Date _____

Print Name of Patient _____