



Estrella Integrative Psychiatry

Daryl Cotton, PMHNP-BC

(623) 640-7682

EstrellaMentalHealthServices@gmail.com

12725 W Indian School Rd, Suite E-101

Avondale, AZ 85392

Fax# (855) 932-1312

CLIENT INFORMATION SHEET – Child or Adult

Patient's Name _____

Date of Birth ____/____/____ Social Security number ____ - ____ - ____

Address _____

City _____ State _____ Zip _____

Home phone _____ ok to leave a message? Y __ N __

Work phone _____ ok to leave a message? Y __ N __

Cell Phone _____ ok to leave message or text? Y __ N __

Email address _____

Mother's Name _____ Date of Birth _____

Fathers Name _____ Date of Birth _____

Marital status (circle one) married divorced never married separated other

Other Guardian Name (if applicable) _____

Other Guardian contact information (if applicable) _____

Emergency Contact Name and Phone _____

Who referred you? _____

INSURANCE INFORMATION

- *Do not complete this portion if paying for services out of pocket*

Patient's Name _____ Patients DOB: ____/____/____

Policy Owner: _____

Policy Owner DOB: ____/____/____ Policy Owner Social Security Number ____/____/____

Policy Owners relationship to Patient _____

Insurance Company Name _____

Policy/member ID # _____ Group # _____

Copay amount \$ _____ Co-Insurance% _____

Deductible yet to be satisfied \$ _____ () Unknown

Policy Owner Address _____

Policy Owner Phone Home/Cell : _____ Work _____

CONSENT FOR TREATMENT

I, _____ authorize therapeutic services for
(parent/guardian/self)

(child's full name)

- **CUSTODY & GUARDIANSHIP ISSUES**

- Consent for services can **ONLY** be authorized by a legal guardian.
- If parents are separated, or divorced with shared custody, services are provided **ONLY** with written consent of **BOTH** parents.
- Copies of legal paperwork (relevant to custody, consent and decision making) are required to document the above information.

- The therapy relationship is a very personal one. This document has been developed in order to ensure there are no misunderstandings about aspects of the services provided. It is important that you read this document carefully and discuss and questions with the Provider (Daryl Cotton). When you sign this document, it represents an agreement between you and Estrella Integrative Psychiatry, whom provides the counseling services and medication management. You may revoke this agreement at any time. By discussing private and often sensitive issues with a trusted professional in a confidential setting, people are often able to free themselves from the difficulties that have inhibited their abilities for joy, happiness, and success. The freedom to be open and honest about such difficulties is essential for therapeutic success; however, talking about sensitive issues can be difficult and cause distress. It is imperative that you communicate any distress you may notice or become aware of with your Provider as soon as possible. There are risks and benefits to mental health treatment. You are free to review your treatment plan at any time and if you disagree with any aspect of it you are invited to discuss the goals with the Provider who will try to offer an acceptable alternative treatment plan. Should you refuse the recommendations, Provider may elect to withdraw services.

Parent/ guardian/Self signature

Date

Estrella Integrative Psychiatry Services Policy

_____ A "Psychiatric Evaluation" consists of a 60-90 minutes session. No – shows or cancelations made less than 24 hours in advanced will require full payment for that session. If you arrive late, your session will not be extended past the allotted 60 minutes and a follow up Psychiatric Evaluation will need to be scheduled.

_____ A "Med Check" consists of a 20 to 45 minutes session (depending on complexity). No – shows or cancelations made less than 24 hours in advanced will require full payment for that session. If you arrive late, your session will not be extended past the allotted time.

_____ Children are to be supervised at all times in the building and outside the building. While in the lobby children must stay in the front portion of the lobby, refrain from looking into therapist windows and remain quiet as to not disrupt other sessions. There is no supervision of children offered.

_____ Any changes in custody, address, contact information, insurance or other pertinent information must be provided to the provider of services in a timely manner.

_____ Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc..), neither you (client's) nor your attorney, nor anyone else acting on your behalf will call on Daryl Cotton to testify in court or at any other proceeding, nor will a disclosure of the psychiatric records be requested unless otherwise agreed upon.

_____ All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled or when client's family members communicate to Daryl Cotton that the client presents a danger to others.

_____ Daryl Cotton consults regularly with other professionals regarding their clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.

_____ If you need to contact your provider between sessions, please leave a voice or text message for Daryl Cotton at (623) 640 -7682 and your call will be returned as soon as possible.

Providers check their messages several times during the daytime only, unless they are out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call Empact 24-hour suicide prevention center 480-784-1500 or the Police: 911. Please do not use e-mail or faxes for emergencies. Your Providers do not check their e-mail or faxes daily.

_____ Requests for copies of records must be made in writing and require 10-14 days.

FEE SCHEDULES INSURANCE INFORMATION

_____ Intake/Initial Psychiatric Evaluation fee \$250.00 (*not applicable if using insurance*)

_____ Med Check/Follow Up visits \$125.00 (*not applicable if using insurance*)

_____ Telephone Consultation (with parents, doctors, school staff, case workers, parenting coordinators & other professionals) \$50 per 15 minutes

_____ Treatment/medication summary letter, letter of clinical recommendations, school form completions, disability paperwork, and other report requests \$25 per page

_____ Copy fee \$50.00 per request

_____ No – show or cancel less than 24 hours in advance \$125.00

_____ Returned check fee \$35.00

_____ Acceptable forms of payment are Most Major Insurance Plans (please check prior to initial Evaluation), Cash, Check, Debit or Credit Card. If using private insurance, they will be billed on the date of service. ***All copays, session fees and additional charges are due at the time of service.***

_____ **Unpaid charges will be turned over to collections after 90 days of non-payment.**

_____ It is your responsibility to verify eligibility, deductible, coverage and copay amounts with your insurance carrier prior to the initial appointment. **If insurance claims are denied it is your responsibility to pay the service fee in full.**

_____ Court appearance if subpoenaed by court (2 hour minimum) \$300.00 per hour.

****PLEASE NOTE: DARYL COTTON IS NOT TO BE CALLED FOR COURT TESTIMONY. WE DO NOT SPECIALIZE IN THIS FIELD AND WILL NOT BE ABLE TO ACCOMMODATE THIS REQUEST. IF DARYL COTTON is SUBPOENAED TO COURT, CHARGES WILL BE \$300.00 PER HOUR (2 HOUR MINIMUM) ****

I have read this form, been given the option of a copy, discussed any questions with Daryl Cotton and agree to its terms.

Printed Name

Signature

Date

Estrella Integrative Psychiatry

Daryl Cotton, PMHNP-BC

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EstrellaMentalHealthServices@gmail.com

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Avondale, AZ 85392

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PRIVACY POLICY

PROTECTING YOUR PRIVACY

To increase your privacy, confidentiality and security: The therapy relationship is a very personal one. By discussing very private and often sensitive issues with a trusted professional in a confidential setting, people are often able to free themselves from the difficulties that have inhibited their abilities for joy, happiness and success. The freedom to be open and honest about such difficulties is essential for therapeutic progress. For that reason, it is important that you are aware that every other person or entity that becomes involved in your treatment may put you at greater risk for having your privacy and confidentiality breached. These may include (but are not limited to) your insurance company, medical personnel, disability care managers, Workman's Compensation, or attorneys.

Risks may include:

- Your diagnosis impacting future insurance coverage should you change insurance carriers voluntarily or via job change.
- Increased potential for identity theft through the sharing of social security numbers or other personal information.
- Computer or other errors resulting in accidental release of information.

You are always welcome to use your insurance, sign Releases of Information, and/or ask for assistance in working with disability claims or Workman's Compensation paperwork. However, when you pay privately for therapy and/or leave other entities out of the therapeutic relationship, you eliminate or significantly reduce these risks. When only you and your Provider are involved in your treatment the situation is simplified: your Provider is legally and ethically bound to maintain confidentiality laws and you are in charge of with whom you choose to share information. (An exception would be legally mandated reporting of child/elder abuse, threats to harm self, or threats to harm others.)

The difference between the costs to you of using your insurance versus maintaining the most privacy possible through paying privately may not be significant. Talk with your provider for more information regarding reducing your risks.

NOTICE OF PRIVACY PRACTICES

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This disclosure is a shorter version of the full, legally required NPP, which you received along with this so refer to it for more information. However, we can't cover all possible situations so please talk your Provider about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with *treatment*, to arrange *payment* for our services, and for some other business activities which are called, in the law, health care *operations*. After you

have read this disclosure we will ask you sign a *Consent Form* to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this. Of course we will keep your health information private but there are some times when

the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings. If a law enforcement official requires to do so.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs. There are some of the situations like these, but which don't happen very often.

RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can ask us to communicate with you about your health and related issues in a particular way or at certain place, which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. *You can even get a copy of these records, but we may charge you
4. If you believe the information in your records is incorrect or missing important Information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing. You must tell use the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from your Provider.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the healthcare we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Estrella Integrative Psychiatry
12725 W Indian School Rd, Suite E-101
Avondale, AZ 85392
Phone: (623) 640-7682

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between **you** _____ and **Estrella Integrative Psychiatry**. When we use the word “you” below, it will mean your child, relative, or other person if you have written his or her name **here** _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and to send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Privacy Offices by calling our office.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Signature of patient or guardian

Date

Printed name of patient or guardian

Relationship to patient(if applicable)

Description of representative’s authority (Guardian/Parent/Self)

Authorization for Release of Information

I, _____, hereby authorize
(Print patient, former patient, parent/guardian or another authorized person)

Estrella Integrative Psychiatry
c/o Daryl Cotton or other agent of company

☒ To disclose information to
☒ Obtain information from

Regarding: _____
(Patient name) (Social Security Number) (DOB)

Recipient: I authorize the release of my health information to the following recipient:

Recipient Name: _____

Address: _____

City, State, Zip: _____

The following information may be disclosed:

- ___ Case Summary
- ___ Discharge Summary
- ___ Treatment Plan
- ___ Progress Notes
- ___ Reciprocal verbal communication
- ___ Other:

Purpose of disclosure: _____ Expiration date: _____

(one year or less from today's date)

To the party receiving this information: If the records disclosed to you pursuant to this authorization contain information related to alcohol and/or drug abuse, HIV/AIDS related information, and/or psychiatric, mental health information, the information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of such information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. This authorization is subject to revocation at any time by written notification to Estrella Integrative Psychiatry and will automatically expire at revocation date or one year from the date on which it was signed. In consideration of this authorization, I hereby release the above parties from any legal liability resulting from the release of this information.

Signature: _____ Date: _____

(Patient, former patient, parent/guardian or another authorized person)

Witness: _____ Date: _____