Reno Psychiatric Associates

80 Continental Drive, Suite 200 ▪ Reno, Nevada 89509
(775) 329-4284 ▪ FAX (775) 329-2550

Gerri Steinagel, MD
Thomas E. Bittker, MD, Ltd.
Mark Armerding, MD
Kathleen Stoll, MD

Mechibelle Lynch, MD
Susan Drymalski, MD
Jesse Reinking, DO
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Thank you for choosing Reno Psychiatric Associates. Enclosed is the paperwork that needs to be completed prior to your appointment. Please bring your completed paperwork along with your insurance card to you appointment. Please arrive 15 minutes prior to your scheduled appointment time. If you do not arrive on time for your scheduled appointment, you will be asked to reschedule.

We will attempt to call you 2 days prior to your appointment to confirm your visit. We require 48 hours notice for changes or cancellations of appointments. Failing to do so may result in a fee.

All copayments, deductibles and/or coinsurances will be collected at the time of check in. **We do not take checks.**

Once again, thank you for choosing our office. We look forward to being of assistance to you.

Appointment: M T W TH F Date: Time:

Dr.

Insurance: Cash Pay:

RENO PSYCHIATRIC ASSOCIATES
80 CONTINENTAL DRIVE, SUITE 200, RENO, NV 89509
(775) 329-4284

Date:_____

Patient Name:_____
Last name First name MI

Physical Address:_____**Primary Phone:**_____
Street

_____**Secondary Phone:**_____
City State Zip Code

Mailing Address (if different):_____

Birthdate:_____**Age:**_____**Sex:**_____**Social Security:** _____

Marital Status(S, M, W, D):_____**Occupation:**_____

Name of Employer:_____**Work Phone:**_____

Names of All Your Health Insurances:_____

Insured Name:_____**Social Security:**_____

Insured's Birthdate_____**Insured's Employer**_____

Person to Contact in Emergency:_____**Phone:**_____

If patient is a minor, name of legal guardian:_____

Address:_____**Phone:**_____

Family Physician:_____**Referred By:**_____

Pharmacy Name & Location_____

Please read and initial the following statements:
1) I give permission for medical information to be shared with my Primary Care Doctor and my insurance company for the purpose of continuation of care_____.
2) I am not currently eligible for Medicaid, and will not be applying for Medicaid Benefits _____.

Reno Psychiatric Associates Payment Policies

1. Professional Fees are due at the time services are rendered. We do not take checks.
2. Professional Services are rendered to the patient, and therefore, it is the patient's responsibility to ensure the payment of the billing.

_____
SIGNATURE DATE

General Health Questionnaire

NAME DATE

FAMILY HISTORY

If any blood relative has suffered any of the following — please indicate which relative.

- ☐ TUBERCULOSIS _____
- ☐ STROKE _____
- ☐ MIGRAINE _____
- ☐ MENTAL ILLNESS _____
- ☐ OBSESSIVE COMPULSIVE DISORDER _____
- ☐ PANIC DISORDER _____
- ☐ ALCOHOLISM _____
- ☐ EPILEPSY _____
- ☐ DIABETES _____
- ☐ CANCER _____
- ☐ ALLERGY _____
- ☐ SCHIZOPHRENIA _____
- ☐ SUBSTANCE ABUSE _____
- ☐ ARTHRITIS _____ ☐ HYPERTENSION
- ☐ GOUT _____ _____
- ☐ KIDNEY DISEASE _____ ☐ HEART ATTACK
- ☐ GLAUCOMA _____ _____
- ☐ MOOD DISORDER (Depression or Manic Depressive) _____
- ☐ ANY OTHER PSYCHIATRIC ILLNESS _____

HOSP ADM

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDS

LIST MEDICATIONS YOU ARE NOW TAKING

_____
_____
_____
_____

DRUG ALLERG

_____
_____
_____
_____

MEDICAL HISTORY

Mark C for current problems. Check ✓ box and indicate age when you had any of the following symptoms or diseases.

MAIN PROBLEMS (1) _____ **(2)** _____ **(3)** _____

- ☐ Decreased Hearing
- ☐ Ringing in Ear
- ☐ Ear Infections - frequent
- ☐ Dizzy Spells
- ☐ Failing Vision
- ☐ Double or Blurred Vision
- ☐ Eye Pain
- ☐ Eye Infections - frequent
- ☐ Nose Bleeds - recurrent
- ☐ Sinus Trouble
- ☐ Sore Throats - frequent
- ☐ Hayfever / Allergies
- ☐ Hoarseness - prolonged
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic Cough
- ☐ Asthma / Wheezing

Shortness of Breath:

- ☐ on Exertion ☐ Lying Flat
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Irregular Pulse
- ☐ Swollen Ankles
- ☐ Fainting Spells
- ☐ Leg Pain when walking
- ☐ Varicose Veins / Phlebitis
- ☐ Loss of Appetite - recent
- ☐ Difficulty Swallowing
- ☐ Indigestion or Heartburn
- ☐ Persistant Nausea / Vomiting
- ☐ Peptic Ulcers
- ☐ Abdominal Pain - chronic
- ☐ Change in Bowel Habits - recurrent
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis
- ☐ Bloody or Tarry Stools
- ☐ Hemorrhoids
- ☐ Gall Bladder Trouble
- ☐ Jaundice / Hepatitis
- ☐ Hernia
- ☐ Urine Infections - frequent
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Overnight Urination - more than 2
- ☐ Control in Urination
- ☐ Decrease in Force of Urination
- ☐ Kidney Stones
- ☐ Venereal Disease
- ☐ Urethral Discharge
- ☐ Chronic Fatigue
- ☐ Weight Loss - recent
- ☐ Anemia ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Convulsions / Seizures
- ☐ Stroke
- ☐ Tremor / Hands Shaking
- ☐ Muscle Weakness
- ☐ Numbness / Tingling Sensations
- ☐ Headaches - frequent
- ☐ Arthritis / Rheumatism
- ☐ Back Pain - recurrent
- ☐ Bone Fracture / Joint Injury
- ☐ Gout
- ☐ Foot Pain ☐ Cold Numb Feet
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Sleeping - difficulty
- ☐ Nervousness ☐ Depression
- ☐ Memory Loss
- ☐ Moodiness - excessive
- ☐ Phobias
- ☐ Mental Illness
- ☐ Chicken Pox ☐ Polio
- ☐ Measles ☐ Germ. Measles
- ☐ Rheumatic ☐ Scarlet Fever
- ☐ Mumps ☐ Tuberculosis
- ☐ Alcohol _____ oz., beers, or glasses wine per day
- ☐ Smoking _____ packs per day
- ☐ Coffee / Tea _____ cups per day

Females - Menstrual History

Age of onset _____ ☐ Reg ☐ Irreg

Flow: ☐ Heavy ☐ Mod ☐ Light

- ☐ Pain / Cramps with Mens. Flow

_____ Days of Flow

_____ Length of Cycle

- ☐ Pain / Bleeding After Sex

No. of Pregnancies _____

No. of Live Births _____

Birth Control Method _____

B.C. Pill (name) _____

- ☐ Flushing / Menopause
- ☐ Require rest or medication w/ periods

Other Symptoms or Diseases

- ☐ _____
- ☐ _____
- ☐ _____

SYNOPSIS

_____
_____
_____

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MEDICATION REFILL POLICY

The following Medication Refill Policy for this office has been set up to provide you, our patient with what we believe to be a safe, effective and uniform level of care.

We process all complete and appropriate refill requests within 2 days of receipt of the request in our office, **EXCEPT ON FRIDAYS AND HOLIDAYS**, when they will not be filled until the next working day.

If your doctor gives you a written prescription, you are expected to take it to the pharmacy. We request that you contact your pharmacy several days before you need any refills so that we can respond to them in a timely manner. Even if your prescription says "no refills", call your pharmacy to request a refill. They will then contact this office. Prescriptions for stimulants (such as ADD medications) must be turned into the pharmacy within 14 days of the date they were written.

As a courtesy to our patients, a doctor in our group is always available to address urgent issues that may arise. However, this "on call" doctor **will not** refill your prescriptions for controlled substances, which includes most anxiety and sleep medications nor will the on call doctor start any new prescriptions for controlled substances. After hours and on weekends, the on call doctor does not have access to your chart and therefore will generally not provide refills.

If your insurance company requires prior authorization for your medications, it may take THEM several days to respond to our requests.

Signature_____

Reno Psychiatric Associates

Controlled Substances Prescription Policy

In 2015 the Nevada legislature passed SB459, which places significant restrictions on how doctors prescribe controlled substances. Because of these laws, we are required to change how we prescribe these medications. These new policies are outlined below.

1. The Nevada Board of Pharmacy maintains an on-line database, and any prescriptions that a patient fills for controlled substances at a Nevada pharmacy will be listed in that database. Before prescribing any controlled substances, your doctor will review your profile in this database. If your profile contains any irregularities, such as excessive numbers of prescriptions, or getting prescriptions from multiple doctors, your doctor may choose not to prescribe any controlled substances for you. This database will be checked again periodically during your course of treatment.

2. You must be examined by your doctor before your doctor can start a new controlled substance or provide any refills for a controlled substance. **Because of this restriction, you the patient must carefully monitor the number of your refills for controlled substances, and you must get in for an appointment with your doctor before you run out of refills.** If you run out of refills, and you cannot get in to see your doctor here in a timely matter, your options are to go to a local urgent care clinic, a hospital emergency department, your primary care provider, or any other available medical provider of your choosing.

3. As a courtesy to our patients, a doctor in our group is always available to address urgent issues that may arise. However, this "on call" doctor **will not** refill your prescriptions for controlled substances, nor will the on call doctor start any new prescriptions for controlled substances.

4. Be advised that our doctors can be very busy, so keeping your scheduled appointment is essential. If you have to cancel or miss an appointment for any reason, it could be months possibly before you can be seen again.

5. If you run out of your controlled substance medication, and you develop any subsequent discomfort, we ask you to proceed to an urgent care clinic or hospital emergency department as soon as possible for evaluation and treatment.

Acknowledged by: _____ _____ _____

Signature Date Printed Name

Version Date: 10/12/2015

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RENO PSYCHIATRIC ASSOCIATES

FOR PATIENTS WITH HMO INSURANCE COVERAGE

Many of our patients have contracted with Health Maintenance Organizations (HMOs) to provide medical insurance.

HMOs require that, as a new patient in this office, you obtain a referral from your Primary Care Physician (PCP) and/or an authorization from your HMO before you can be treated by us. If this authorization is not received by us by the time of your appointment, you may elect to reschedule the appointment, or accept the responsibility for paying the entire fee for the visit.

If your plan requires that you obtain additional authorizations for ongoing treatment, we will assist you in obtaining the necessary authorizations.

It is a requirement of the HMOs that the entire co-payment is due at the time of service.

We respectfully request your cooperation in following the requirements of your HMO in these matters.

Thank you for choosing us to provide your mental health care.

* *

"I agree to pay the entire fee for services should my HMO deny payment for medical services due to my non-compliance or due to lack of coverage."

SIGNATURE_____DATE_____

RENO PSYCHIATRIC ASSOCIATES
COMPLIANCE ASSURANCE & CONSENT FORM – HIPAA

COMPLIANCE ASSURANCE NOTIFICATION

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any services so that we may remedy the situation promptly.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We intend to ensure the confidentiality of all medical information and communication. Please be aware that there are several exceptions to these confidentiality guidelines, including the following:

- In instances where the health and safety of patients and others are in jeopardy, the law may require us to divulge information to law enforcement officials or state adult and child welfare agencies.
- Information required to facilitate insurance coverage for a medical or psychiatric problem.
- Information relevant to litigation (lawsuits) when such confidential information is critical to the resolution of that litigation.
- Information gathered as part of an examination that is not therapeutic in intent, but rather commissioned by an outside agency with the endorsement and permission of the examinee, e.g. an examination requested by an employer in order for an employee to return to work.
-

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our Privacy Notice.

SIGNATURE_____DATE_____

PRINT NAME_____

RENO PSYCHIATRIC ASSOCIATES
OFFICE AND FINANCIAL POLICIES

Thank you for choosing us as your health care providers. We are committed to your successful treatment.

FINANCIAL POLICIES:

Please understand that payment of your bill is considered to be a part of your treatment. The following is a statement of our financial policies, which we require you to read and to sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
(with the exception of certain insurance coverages)
WE ACCEPT CASH, VISA, M/C AND DEBIT CARDS

REGARDING INSURANCE:

We cannot bill your insurance without a copy of your insurance card. We will only bill your insurance for you if we are contracted providers with your insurance company. All co-pays and deductibles are due at the time of service. If your insurance company has not paid your account within 45 days, you will be required to pay your balance in full. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered "reasonable and necessary" under the Medicare Program and/or other medical insurances. Should the account be referred to a collection agency or an attorney for collection, the undersigned agrees to pay reasonable attorney's fees and/or collection fees.

MISSED APPOINTMENTS:

Our policy is to charge the full fee for missed or cancelled appointments, at the rate of a normal office visit, unless it is cancelled at least 24 hours in advance. This charge is not billable to your insurance, and payment is your responsibility. Payment is expected at the time of the next office visit, or sooner. Please help us to serve you and all our patients better by keeping your scheduled appointments.

PRESCRIPTION REFILLS

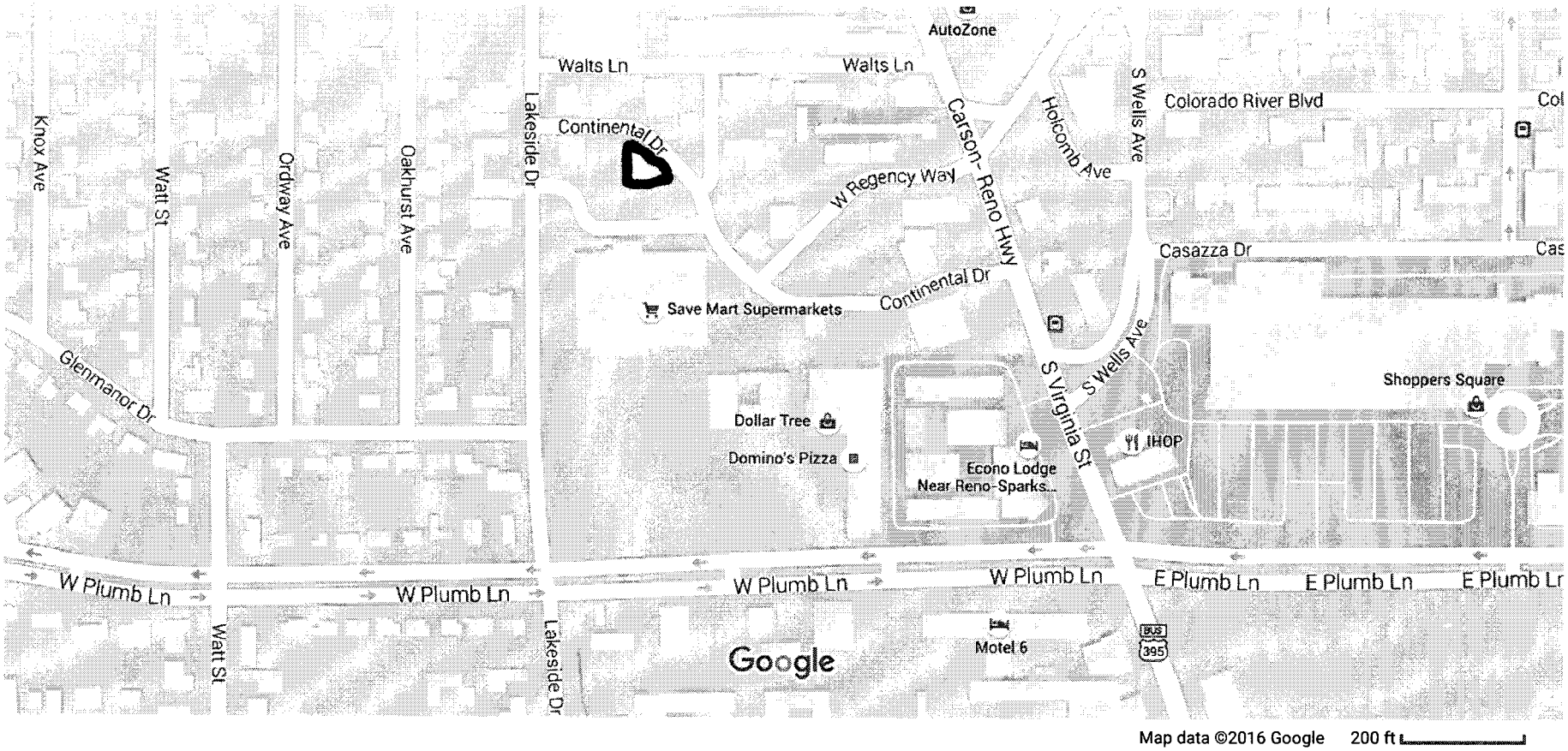
Any requests to refill prescriptions may take up to 48 hours after being received in the office. Please do not wait until you are out of medication to contact us.

* *

"I have read the above policies, understand them, and agree to abide by them."

SIGNATURE_____DATE_____

Google Maps


AutoZone
Walts Ln
Walts Ln
Continental Dr
W Regency Way
Carson- Reno Hwy
Holcomb Ave
S Wells Ave
Colorado River Blvd
Casazza Dr
Continental Dr
Save Mart Supermarkets
Knox Ave
Watt St
Ordway Ave
Oakhurst Ave
Lakeside Dr
Glenmanor Dr
Dollar Tree
Domino's Pizza
Econo Lodge Near Reno-Sparks...
S Virginia St
S Wells Ave
IHOP
Shoppers Square
W Plumb Ln
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