

Reno Psychiatric Associates
80 Continental Drive Ste 200 * Reno, NV 89509
775 329-4284 * Fax 775 329-2550

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

Mechibelle Lynch, MD
Susan Drymalski, MD
Joan Winkler, MA, MFT, LADC

Thank you for choosing Reno Psychiatric Associates. The following is the paperwork that needs to be completed prior to your appointment. We will need to have a copy of your insurance card as well as a photo ID. Please arrive 15 minutes prior to your appointment. If you do not arrive on time for your scheduled time, 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. Unconfirmed appointments are subject to cancellation.

All copayments, deductible 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.

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

City State Zip Code Secondary Phone: _____

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.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> TUBERCULOSIS _____ | <input type="checkbox"/> EPILEPSY _____ | <input type="checkbox"/> ARTHRITIS _____ | <input type="checkbox"/> HYPERTENSION _____ |
| <input type="checkbox"/> STROKE _____ | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> GOUT _____ | |
| <input type="checkbox"/> MIGRAINE _____ | <input type="checkbox"/> CANCER _____ | <input type="checkbox"/> KIDNEY DISEASE _____ | <input type="checkbox"/> HEART ATTACK _____ |
| <input type="checkbox"/> MENTAL ILLNESS _____ | <input type="checkbox"/> ALLERGY _____ | <input type="checkbox"/> GLAUCOMA _____ | |
| <input type="checkbox"/> OBSESSIVE COMPULSIVE DISORDER _____ | | <input type="checkbox"/> MOOD DISORDER (Depression or Manic Depressive) _____ | |
| <input type="checkbox"/> PANIC DISORDER _____ | <input type="checkbox"/> SCHIZOPHRENIA _____ | <input type="checkbox"/> ANY OTHER PSYCHIATRIC ILLNESS _____ | |
| <input type="checkbox"/> ALCOHOLISM _____ | <input type="checkbox"/> SUBSTANCE ABUSE _____ | | |

H O S P I T A L	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

M E D I C 	LIST MEDICATIONS YOU ARE NOW TAKING		A D D I T I O N S	

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) _____

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Decreased Hearing
<input type="checkbox"/> Ringing in Ear
<input type="checkbox"/> Ear Infections - frequent
<input type="checkbox"/> Dizzy Spells
<input type="checkbox"/> Failing Vision
<input type="checkbox"/> Double or Blurred Vision
<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Eye Infections - frequent
<input type="checkbox"/> Nose Bleeds - recurrent
<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Sore Throats - frequent
<input type="checkbox"/> Hayfever / Allergies
<input type="checkbox"/> Hoarseness - prolonged
<input type="checkbox"/> Pneumonia / Pleurisy
<input type="checkbox"/> Bronchitis / Chronic Cough
<input type="checkbox"/> Asthma / Wheezing
Shortness of Breath:
<input type="checkbox"/> on Exertion <input type="checkbox"/> Lying Flat
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Irregular Pulse
<input type="checkbox"/> Swollen Ankles
<input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Leg Pain when walking
<input type="checkbox"/> Varicose Veins / Phlebitis
<input type="checkbox"/> Loss of Appetite - recent
<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Indigestion or Heartburn
<input type="checkbox"/> Persistent Nausea / Vomiting
<input type="checkbox"/> Peptic Ulcers
<input type="checkbox"/> Abdominal Pain - chronic
<input type="checkbox"/> Change in Bowel Habits - recurrent
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation
<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Bloody or Tarry Stools
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Jaundice / Hepatitis
<input type="checkbox"/> Hemia
<input type="checkbox"/> Urine Infections - frequent
<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Overnight Urination - more than 2
<input type="checkbox"/> Control in Urination
<input type="checkbox"/> Decrease in Force of Urination
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Urethral Discharge | <input type="checkbox"/> Chronic Fatigue
<input type="checkbox"/> Weight Loss - recent
<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Convulsions / Seizures
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tremor / Hands Shaking
<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Numbness / Tingling Sensations
<input type="checkbox"/> Headaches - frequent
<input type="checkbox"/> Arthritis / Rheumatism
<input type="checkbox"/> Back Pain - recurrent
<input type="checkbox"/> Bone Fracture / Joint Injury
<input type="checkbox"/> Gout
<input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet
<input type="checkbox"/> Rashes <input type="checkbox"/> Hives
<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema
<input type="checkbox"/> Sleeping - difficulty
<input type="checkbox"/> Nervousness <input type="checkbox"/> Depression
<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Moodiness - excessive
<input type="checkbox"/> Phobias
<input type="checkbox"/> Mental Illness | <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio
<input type="checkbox"/> Measles <input type="checkbox"/> Germ. Measles
<input type="checkbox"/> Rheumatic <input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Mumps <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Alcohol _____ oz., beers, or glasses
wine per day
<input type="checkbox"/> Smoking _____ packs per day
<input type="checkbox"/> Coffee / Tea _____ cups per day
Females - Menstrual History
Age of onset _____ <input type="checkbox"/> Reg <input type="checkbox"/> Irreg
Flow: <input type="checkbox"/> Heavy <input type="checkbox"/> Mod <input type="checkbox"/> Light
<input type="checkbox"/> Pain / Cramps with Mens. Flow
_____ Days of Flow
_____ Length of Cycle
<input type="checkbox"/> Pain / Bleeding After Sex
No. of Pregnancies _____
No. of Live Births _____
Birth Control Method _____
B.C. Pill (name) _____
<input type="checkbox"/> Flushing / Menopause
<input type="checkbox"/> Require rest or medication w/ periods
Other Symptoms or Diseases

_____ |
|---|---|--|--|

SYNOPSIS

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.
Mechibelle Lynch, MD

Kathleen Stoll, MD
Susan Drymalski, MD
Joan Winkler, MA, MFT, LADC

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

**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 (HIPAA) 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

Please understand that payment of your bill is considered to be 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 coverage)
WE ACCEPT CASH, VISA, MASTERCARD AND DEBIT CARDS
WE DO NOT ACCEPT CHECKS

INSURANCE:

We cannot bill your insurance without a copy of your insurance card and driver's license. We will only bill your insurance for you if we are contracted providers with your insurance company. You are responsible for all unpaid charges including those that fall outside of the terms and conditions of your insurance plan. 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 Medicare and/or other medical insurances. Some services not covered by insurance include telephone consultations, letters, filling out forms, or missed appointment charges.

If you continue to have an unpaid balance without a payment arrangement made with your provider, your treatment services through RPA may be terminated. Should the account be referred to a collection agency or an attorney for collection, you agree to pay reasonable and/or collection fees.

MISSED APPOINTMENTS/LATE CANCELLATIONS;

Keeping scheduled appointments is an important part of your treatment. Sporadic attendance hinders the efforts of those trying to help you, and limit the effectiveness of your treatment. Missed appointments are not only a loss for you, but also to your provider and other patients that could have been seen. Our policy is to charge a fee for missed or late cancelled appointments. An appointment cancelled less than 24 hours prior to your scheduled meeting is considered to be late. This charge is not billable to your insurance. Payment is expected by the time of the next office visit.

Continued missed appointments and/or late cancellations may lead to termination of treatment services. In this case, you will be notified by certified letter that you will no longer be receiving services from RPA. You will be provided with up to thirty days of urgent care while you secure a new provider. After thirty days you will no longer be considered an active patient

at RPA. No further treatment (appointments, phone calls, prescription refills, etc.) will be provided. As a courtesy to our patients, our office staff will remind our patients of their appointments the day prior to the appointment. Please make sure that we have your current phone number on file.

ON-CALL PHYSICIAN SERVICE:

RPA has one of the physicians in our group available to address urgent issues that may arise after hours or when your regular psychiatrist is not available during working hours. Generally, urgent issues are considered medication related. For example, if you have questions about possible side effects or dose change. This on call doctor will not start new medications and will not prescribe controlled substances, which includes most anxiety and sleep medications, as well as stimulants.

If you are in a crisis situation or feeling suicidal, call 911 or go to your local Emergency Department. The Crisis Call Center (800-273-8255) is also available 24/7.

PRESCRIPTION REFILLS:

We process all complete and appropriate refill requests within 2 days of receipt of the request in our office. THE EXCEPTION TO THIS 2 DAY TURN AROUND TIME IS FRIDAYS AND HOLIDAYS, when the request will be filled the next working day. Please contact your pharmacy several days in advance before medication is due so we can respond in a timely manner.

If your doctor gives you a written prescription, you are expected to take it to the pharmacy. Please be aware that stimulant medications (e.g. Adderall, Ritalin, Dexadrine, Vyvanse) must be turned in to your pharmacy within **14 Days** of the date the prescription was written. If you do not turn in the prescription by this time your pharmacy will not fill it. **If your doctor needs to rewrite a prescription because you did not turn it into the pharmacy on time, there will be a fee charged that is not billable to your insurance.**

If your insurance company requires prior authorization for your medication, it may take your insurance company several days to process the request. If you do not receive information on a prescription within a week of discussing the prescription with your doctor, please call your insurance company to check on the status of the prior authorization.



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

PRINTED NAME _____ **DATE** _____

SIGNATURE _____

Google Maps

