H. J. Schulte, M.D., F.A.P.A.

Board Certified
Psychiatry

Distinguished Fellow
American Psychiatric Association
Adolescent/Adult/Geriatric

Office Policy and Procedures

The office policies and procedures listed below are designed to make your care with our practice more efficient. Please feel free to ask any questions you may have. When you have read and agree to the following, sign your name below.

Payment & Missed Appointments

PAYMENT IN FULL IS REQUIRED AT EACH VISIT. There is a full fee charge for no shows and late cancellations without 24 business hour notice. There is a $35.00 charge for all returned checks. By signing below, you acknowledge that you will not be using insurance or Medicare to cover the cost of treatment. We do not accept any type of insurance or Medicare.

If you are fifteen minutes late for your scheduled appointment, we reserve the right to reschedule you to another day or time. **If an appointment is missed or cancelled with less than a 24 business hour notice, you will be billed the scheduled fee.** Appointment cancellations for Mondays must be received by Friday no later than 1:00PM to avoid a charge.

The office staff will not schedule further appointments if your account is past due by two (2) weeks. We provide you with medical service; please provide us with prompt payment and attendance to your appointment.

Due to a significant increase in paperwork as generated by the managed care and disability insurance companies, we need to charge for time spent completing extra paperwork on behalf of patients; $90.00 for short form (2 pages or less) and $175.00 for 3 pages or more; due in advance or upon receiving a bill. This includes forms for pre-authorizing medications. Letters are charged for on a case by case basis.

New Patient Private-Pay Deposit Policy

I understand that a deposit in the amount of $495.00 must be received upon making your initial appointment. This sum will be applied toward the $495.00 charge due at the time of the first visit. This deposit will be refunded in full if I cancel the appointment, so long as I give a notice to the office 48 business hours prior to my appointment. If you do not appear at your initial appointment and do not call within the deadline described above, this deposit will not be refunded.

General Policies

If you have questions or concerns for Dr. Schulte, please call the office and leave a message with the staff. Please allow 24 hours for the staff and or Dr. Schulte to return your call. We will do our best to get back with you sooner.

We have a 48-hour turnaround time for prescription renewal. Please contact your pharmacy with your request for a refill and they will fax a request to us. If you are requesting a new prescription, our pharmacy line number is 480-941-9004. We do not renew prescriptions on the weekend. You must see Dr. Schulte for medication evaluations as he determines.

Signature: _____ **Date:**_____

7101 East Indian School Road ♦ Scottsdale, Arizona 85251
Phone: (480) 941-9004 ♦ Fax: (480) 941-9361

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Patient Information

(Please print clearly)

Name: _____ D.O.B:_____

Male: _____ Female: _____ Marital Status: _____

Address:_____

City: _____ State: _____ Zip: _____ Email:_____

Cell Phone: _____ Home Phone: _____

Employer: _____

Emergency Contact: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Referred By: _____

CONFIDENTIALITY

In divorce situations where both parties have been part of counseling, your records are not released unless both parties sign an authorization form.

CONSENT FOR TREATMENT

I authorize and request Dr. H. Jim Schulte to carry out psychiatric examinations, treatment, and/or diagnostic procedures, which now or during my care as a patient, are considered by Dr. Schulte to be advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at time be difficult and uncomfortable.

Sign: _____ Date: _____

If you are younger that 18 years of age, please provide the name, address and phone number of person responsible for the bill:

Name: _____ Phone: _____

Address: _____

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchases without using your health insurance. Also, over the counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow Dr. H. Jim Schulte to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

_____ _____
Patient/Parent/Guardian Signature Date

By signing this consent form, you are giving Dr. H. Jim Schulte permission to collect, and giving your pharmacy and your health insurer permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medications used to treat mental health issues.

Preferred Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone: _____

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Medical History

Please list any prescriptions you currently use (name, dosage, frequency):

_____

_____

_____

_____

When did you last have a physical exam? _____

Who did you see? _____ Phone _____

Psychiatric History

Have you had psychiatric or psychological treatment of any kind before? Yes___No___

If you checked "yes" to the above question, please answer the following:

What type of care did you receive: In patient(hospital)_____ outpatient_____Both_____

Where were you treated? _____When:_____

How long? _____ Therapist/Doctor _____Phone_____

Did your doctor prescribe medicine at that time? Yes_____ No_____

Please indicate how your issues are affecting the following areas of your life: please circle applicable number on each line your responses will be used only for Dr. Schulte. Your privacy and anonymity are guaranteed.

	No effect	**Little Effect**	**Much Effect**	**Significant Effect**	**Not Applicable**
Marriage/Relationship	1	2	3	4	na
Family	1	2	3	4	na
Job/School	1	2	3	4	na
Friendships	1	2	3	4	na
Hobbies	1	2	3	4	na
Financial Situation	1	2	3	4	na
Physical Health	1	2	3	4	na
Anxiety level/Nerves	1	2	3	4	na
Mood	1	2	3	4	na
Eating Habits	1	2	3	4	na
Sleeping Habits	1	2	3	4	na
Ability to Concentrate	1	3	3	4	na

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Health Care Coordination Form
Consent to Release of Information to Primary Physician (or referring practitioner)

Patient name _____DOB: _____

I hereby authorize the release of the medial information listed below which pertains to my medical, mental or physical condition or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis to my primary physician.

Referring Provider _____

Address _____

Phone Number _____ Fax _____

I understand that the release of the information is to permit my primary care physician to monitor my health status and to coordinate all the care, which I may receive from Dr. Schulte. The authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. I understand that the information authorized by the release will be provided to the authorized recipient only. Additional information may be provided to the recipient only with signed consent from me. I further understand that I have the right to receive a copy of the authorization upon my request.

_____ _____
Signature of patient or legal guardian Date

Dear _____,

I wish to inform you that your patient _____

Was referred to me for treatment on _____

The DSM-V diagnosis is_____

Outpatient care is being delivered and the treatment plan consists of the following modalities:

_____ Individual psychotherapy
_____ Couples Therapy
_____ Family Psychotherapy
_____ Medication Management
_____ Group Psychotherapy
_____ Other _____

Medications/Treatment managed by Dr. Schulte

_____

_____

_____

_____

_____
Dr. Schulte's Signature

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____

acknowledge that I have received a copy of Dr. Schulte's Notice of Privacy Practices. This Notice describes how the practice may use and disclose my protected health information (PHI), certain restrictions on the use and disclosure of my healthcare information, and the rights I have regarding my protected healthcare information.

PATIENT DISCLOSURE FORM

I authorize this practice to disclose to the following persons my protected healthcare information, until such time that I object to such disclosure and provide in writing to Dr. Schulte any changes and or deletions from this list:

1._____ 4._____

2. _____ 5. _____

3. _____ 6. _____

_____ _____
Signature of Patient or Guardian Date

_____
Signatory Relationship to Patient

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PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: Date:

PHQ9 **Over the last two weeks how often have you been bothered by the following problems?**		**0** Not at all	**1** Several Days	**2** More than half the days	**3** Nearly every day
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Severity Score	Mild depression = 5 – 10 Moderate depression = 10 – 18 Severe depression = 19 – 27	Total Score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

GAD7 **Over the last two weeks how often have you been bothered by the following problems?**	**0** Not at all	**1** Several Days	**2** Over than half the days	**3** Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Board Certified Psychiatrist
Board Certified Addictionologist

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Rapid Mood Screener

Item	Response	
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	YES	NO
2. Did you have problems with depression before the age of 18?	YES	NO
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	YES	NO
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	YES	NO
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	YES	NO
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	YES	NO

Name:_____ **Date:**_____