Patient Name: _____ D.O.B: _____Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers (home) (_____) _____(cell) (_____) _____

Email Address _____

SSN_____

Emergency Contact(s) Information:

Name	Relationship to you	Phone Number

Who can we share information with?_____

Social and Occupational History

Current Marital Status (circle one): single separated divorced widowed married domestic partner

Are you currently employed? YES NO

Are you on disability? YES NO

(initial) _____Regardless of your insurance Arizona Recovery Center collects $120 annually for a patient deposit. This deposit remains on account and will be used for patient responsibilities, deductibles and no-show fees. There is a fee of $120 for a No-Show of your initial visit. All other no-shows are subject to $60 fee.

What Problems are you seeking help for?

_____

_____

_____

Past Medical History:

Heart: angina heart attack CHF high blood pressure arrhythmia pacemaker heart murmur,
other _____

Lungs: asthma emphysema supplemental oxygen sleep apnea COPD,

other _____

CNS: seizure stroke headache head injury

other _____

GI: ulcer gastritis liver disease cirrhosis hepatitis A B C constipation diarrhea
other_____

Blood: anemia bleeding sickle cell disease

other _____

Endocrine: thyroid disease diabetes
other_____

Infectious: HIV-AIDS endocarditis abscesses osteomyelitis
other_____

Musculoskeletal: arthritis fibromyalgia rheumatoid arthritis,
other_____

Psychiatric: ADD OCD Bipolar Schizophrenia PTSD Depression Anxiety,
other_____

Do you have chronic pain issues, if so describe.

_____

Past Surgical History: (please list operations and dates)

_____

_____

Please list all medication(s) you are currently taking:

_____

_____

_____

Are you allergic to any medications please list below:

_____

Past Mental Health History

Have you ever had outpatient treatment by a psychiatrist? Yes / No

Have you ever received counseling or psychotherapy in the past? Yes / No

Have you ever been hospitalized for psychiatric reasons? Yes / No

Have you ever received substance abuse treatment? Yes /No

Have you ever been hospitalized due to drug or alcohol use/overdose/detox? Yes /No

Please explain any questions you answered yes to above_____

_____

_____

_____

Previous and Current Drug Use

Opioid Use History (Norco, Percocet, Oxycodone, Morphine, Methadone, Heroin, Kratom):

Are you currently using opiates? **Yes / No**

Are they prescribed to you? **Yes /No**

Do you feel you have a problem controlling? **Yes / No**

Alcohol Use History

Are you currently using alcohol? **Yes / No**

Do you feel you have a problem controlling? **Yes / No**

If yes, how many times per week?_____How many drinks per day_____

Sedative Use History (Xanax, Ativan, Klonopin)

Are you currently using sedatives? **Yes / No** Are they prescribed to you? **Yes /No**

Do you feel you have a problem controlling how much you take? **Yes / No**

Stimulant Use History (Methamphetamine, Cocaine or Adderall)

Are you currently using stimulants? **Yes / No**

Do you feel you have a problem controlling how much you take? **Yes / No**

Patient Name: _____ DOB: _____

Patient Responsibility/HIPAA

I understand and agree that I am financially responsible for all charges for all services rendered.
I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, or any other type of benefit limitation for the services I receive.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.
I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

I understand that if my primary insurance does not automatically send my claim to my secondary insurance, I will need to pay the balance owed to ARC, and it is my responsibility to file the claim with my secondary insurance.
ARC does not bill secondary insurances.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Arizona Recovery Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g., my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signature _____ Date _____

Patient Name: _____ DOB: _____

Office Policy:

- I must call 24 hours prior to an appointment to cancel or reschedule my appointment. If I do not provide the notice, my account will incur a $60 no show fee. There is a $120 fee for all new patient appointments.
- I understand my provider may communicate with other providers regarding my medical care, consistent with HIPAA guidelines. I understand that communication pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence may occur and may contain confidential information.
- I will submit my own urine specimen for drug screen upon my provider's request. I also understand that Arizona Recovery Center uses random urine screens, and I may be selected on a random list and if notified – I will have 24 hours to comply. All Urine Drug Screens may be subject to a $35 office fee.

Medications and controlled substances:

- I will safeguard my written prescription and medication from loss, damage, or theft. A lock box is recommended, especially for those with children. Lost, stolen or damaged prescriptions/medications may be replaced at the provider's discretion.
- I will not fill controlled substance medications from other providers if receiving controlled substance mediations from Arizona Recovery Center without first discussion with an ARC provider.
- (For women of childbearing potential) I agree to tell my provider if I become pregnant or even think I may be pregnant. Being pregnant does not disqualify you from treatment but may change your treatment plan for the safety of you and your baby.
- I understand that suddenly stopping heavy alcohol use can be dangerous and deadly. I understand that withdrawal may be life threatening and if any signs occur, I will call 911.
  I understand that if I am prescribed an injectable medication there may be a reaction at the site of injection. Reactions include pain, tenderness, induration, swelling, redness, bruising and itching. Serious injection site reactions including tissue death may occur. I should seek medical attention for worsening skin reactions.
- Regarding opiate treatment: It has been explained to me and I understand that Buprenorphine (Suboxone) itself is an opiate drug, although a partial agonist, it can still produce physical dependency in non-opiate dependent patients. Once I start Buprenorphine, I must be weaned off and cannot stop abruptly without withdrawal symptoms.

The Therapeutic Process

Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. Counseling may help you to change how you view things in your life, how you engage in relationships and how your view yourself. Arizona Recovery Center uses talk therapy that may include homework assignments to help you reach your goals. We cannot promise that your behavior or circumstances will change. You may choose to discontinue counseling at any time. Client Rights

- Counseling sessions are your time. You have the right to participate in developing, reviewing and revising a treatment plan that meets your needs. You have the right to refuse treatment and withdraw your consent for treatment at any time.

Notification of Supervision

- I understand that the assessment/counseling services may be provided by a Behavioral Health Technician who will be under the supervision of Kristen Long, MS, LPC, MAC. During the period of supervision, Kristen Long, MS, LPC, MAC will have unrestricted access to my entire file. This authorization is given with my understanding that by law, the clinician must report any disclosed or suspected child or elder abuse or any serious threat to safety of self or others.
- Kristen Long, MS, LPC, MAC can be reached at Arizona Recovery Center, 84 Acoma Blvd. N Ste 104 Lake Havasu City, Arizona. 928-733-5101
- BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO PARTICIPATE IN ASSESSMENT, DIAGNOSIS AND TREATMENT WITH ARIZONA RECOVERY CENTER.

Signature _____ Date _____

Patient Name: _____ DOB: _____

Today's Date: _____

Over the last two weeks, how often have you been bothered by the following?

	Not at all	Several Days	More than half the days	Nearly Everyday
Feeling nervous, anxious or on edge?	0	1	2	3
Not being able to stop or control worrying?	0	1	2	3
Worrying too much about different things?	0	1	2	3
Trouble relaxing?	0	1	2	3
Being so restless that it is hard to sit still.	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid, as if something awful might happen?	0	1	2	3

Column Totals _____ + _____ + _____ + _____ =

Total Score _____

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly everyday
Little interest or pleasure in doing things.	0	1	2	3
Felling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much.	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching tv	0	1	2	3
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	0	1	2	3
Thoughts that you would be better off dead or hurting yourself.	0	1	2	3
Add columns		_____ +	_____ +	_____

Total _____

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**

I, _____hereby authorize _____to release confidential health information concerning my physical health, mental health and/or substance use disorders to the party listed below.

Information to be released:

- Complete records
  - Lab reports including drug screens.
  - Treatment records
  - Medication records
  - Progress notes
  - Care plans

Please release my medical records to the following healthcare provider/person/facility/entity:

Arizona Recovery Center – Emily Vona, FNP-C

84 Acoma Blvd. North Suite 104 Lake Havasu City, Arizona 86403

Phone: 928-733-5101 Fax: 610-273-5590

Email: emily@AZRecover.com

Signature_____Date_____

Patient Name_____DOB_____

Address_____

City, State, Zip_____

I, _____hereby authorize Arizona Recovery Center to release confidential health information concerning my physical health, mental health and/or substance use disorders to the party listed below.

Please release my medical records to the following healthcare provider/person/facility/entity:

Facility: _____

Point of Contact (first and last) _____

Email _____ Phone: _____

Signature_____Date_____

Patient Name_____DOB_____

Address_____

City, State, Zip_____