Caplan & Associates, LLC
Child, Adolescent, & Adult Psychiatry

Jane E Caplan, MD, Charissa Lopez, PMHNP-BC

11020 N. Tatum Blvd., Suite E-100, Phoenix, AZ 85028

(Office) 602-324-4622 **(Fax)** 602-773-0873 **(Billing)** 480-717-1875
(Email) JEC-AR100@protonmail.com

Patient Demographic Information

Patient's Full Name:			
Cell Phone:	Email:		
Date of Birth (mm/dd/yyyy):	Age:	Gender: M F T	
Home Address:	City:	State:	Zip Code:

If Patient is a Minor, Please Fill out the Following:

*If over the age of 18 please skip to the Emergency Contact portion

Mother's Full Name:	Primary Contact (Check One): Yes No		
Primary Phone: (M/H/W)	Secondary Phone: (M/H/W)		
Email Address: (Please provide a personal email instead of a business email for privacy Practices)			
Home Address: (If Different From Patient)	City:	State:	Zip Code:
Marital Status: ☐ Married ☐ Remarried ☐ Single ☐ Divorced ☐ Widowed ☐ Separated _____# of Years			

Check box if this email is to receive billing statements and invoices

Father's Full Name:	Primary Contact (Check One): Yes No		
Primary Phone: (M/H/W)	Secondary Phone: (M/H/W)		
Email Address: (Please provide a personal email instead of a business email for privacy Practices)			
Home Address: (If Different From Patient)	City:	State:	Zip Code:
Marital Status: ☐ Married ☐ Remarried ☐ Single ☐ Divorced ☐ Widowed ☐ Separated _____# of Years			

Check box if this email is to receive billing statements and invoices

Person to Contact In case of an Emergency:

Full Name:	Relationship:
Primary Phone: (M/H/W)	Secondary Phone: (M/H/W)

Billing /Responsible Party Information (If Different From Above):

Name of Responsible Party:	Relationship:		
Primary Phone: (M/H/W)	Secondary Phone: (M/H/W)		
Email Address: (Please provide a personal email instead of a business email for privacy Practices)			
Home Address:	City:	State:	Zip Code:

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Patient Medical History:

Patient Full Name:____ DOB:________________

Referred By:____

Current Medical Problems:

Past Medical Problems or Surgeries:

History of Head Injury:

No / Yes (Explain)

Allergies to Medication

Current Medications:

No / Yes (Please List)

Past Medication Trials

No / Yes (Please List)

Patient signature Date
(or Full Name & Signature of Responsible Party if a Minor)

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Consent for Electronic Communication

Function of Electronic Communication:

Administrative E-Communication: The patient portal and email can be used for appointment scheduling, prescription refills, billing services and questions, and contact information for referrals to other healthcare providers.

Clinical E-Communication: Any clinically relevant material in the email will be brought up in session. You may provide clinical information via email, but Dr. Caplan and or Charissa Lopez will not necessarily respond to clinical material via email and will instead bring it up at the next appointment so a conversation can occur.

Patient Portal:
We recommend patients to sign up for our patient portal for communication with Dr. Caplan or Charissa Lopez outside of your scheduled appointments. You will be able to see upcoming scheduled appointments, request an appointment, request prescription refills or send messages or documents to your provider. The office will send you an invitation after your initial appointment is scheduled to sign up at: **www.patientfusion.com**.

Email:
EMAIL IS NOT TO BE USED FOR EMERGENCIES!
Emails to Jane Caplan, MD at **jcaplanmd@protonmail.com** or Charissa Lopez, PMHNP-BC at: **calopezNP@protonmail.com** will be checked every 24-48 hours. Protonmail uses encryption, which makes emails unintelligible to unauthorized parties.

Patients are advised not to use an employer-based email address for communication with our practice as employers have a right to access your company email and your psychiatric information may be exposed.

Caplan & Associates, LLC billing service uses Intuit QuickBooks online to provide billing statements and/or itemized invoices. The invoices may be used as “superbills” to be sent by the patient for insurance reimbursement. The billing service email address is: **JEC-AR100@protonmail.com**. Emails directed to this service will be read by the billing staff and/or Dr. Caplan and Charissa Lopez.

Electronic Medical Record/Practice Fusion:
For appointment reminders, Practice Fusion has consent to utilize the following methods of communication: **(Please Check all that Apply):**

Text Message/Phone **Email**

I have read, understand, and accept the guidelines of this consent for electronic communications as described above and any questions I have had have been answered satisfactorily.

____
Print Patient Name Date of Birth

____
Patient signature Date
(or responsible party if a minor)

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PHYSICIAN-PATIENT AGREEMENT

This agreement serves to inform patients of Caplan & Associates, LLC regarding office policies, physician policies, and the physician-patient relationship. Please read this agreement in its entirety and sign where indicated to acknowledge your understanding of this agreement and to abide by the policies contained therein.

ATTENDANCE POLICY: Dr. Caplan requires that all patients taking medication be seen on a regular basis, as determined by the individual needs of each patient. Follow up recommendations will be discussed at the time of the appointment. CII medication (generally stimulants) need to be seen **at least** every 3 months. Patients must call to schedule in advance of these dates. Failure to maintain a regular attendance schedule may affect your ability to receive refills in a timely manner and/or to continue being seen in the practice.

PRESCRIPTION POLICY: Please leave prescription requests on either voicemail or email. For paper ("hard copy") prescriptions please: allow AT LEAST 48 hours for processing; for non-paper (e-prescribe) prescriptions, please allow 24-48 hours for processing.
**Please make sure to allow enough time for processing on all prescriptions, especially on weekends, so that you do not run out of your medication.

CONFIDENTIALITY POLICY: Please see "Notice of Privacy Practices"

RE: THE MEDICAL INFORMATION BUREAU: Health insurance policies sometimes require patients to release all encounter information for any service rendered that is claimed against the health care plan. The diagnosis and treatment information required on the claim form is often then forwarded to the Medical Information Bureau (MIB), where it becomes available to other insurance companies without the patient's knowledge or consent. For this reason, Dr. Caplan cautions all patients that the release of any information through the claims filing process *may* present a potential risk that could be personally damaging to unknowing patients should a third-party gain access to the MIB national database.

MEDICARE PART B ENTITLEMENT POLICY: While Caplan & Associates will gladly treat patients who are Medicare eligible, the practice does not participate in the Medicare Part B program. Unfortunately, this means that Medicare eligible patients are not allowed to seek Medicare reimbursement for this practice's services and are required by law to sign an "Medicare Private Contract" acknowledging the same *prior* to receiving services.

PATIENT/PHYSICIAN RESPONSIBILITIES: Each patient is responsible for providing accurate contact and billing information. If a patient's telephone, email, or address changes, it is the duty of that patient to inform our office immediately to avoid disruption of communication.
Examination and treatment provided by Caplan & Associates is limited to outpatient psychiatric services. The patient should be aware that this does not necessarily constitute total or definitive psychiatric care, and that further evaluation and treatment may be required in some cases. It is the patient's responsibility to obtain follow up medical care for general health as needed or where when advised to do so by the providers of Caplan & Associates, LLC. The patient further acknowledges that psychiatry is a specialty within the field of medicine and is not meant to be a substitution for primary medical care.

TERMINATION POLICY: Caplan & Associates, LLC reserves the right to terminate any patient who violates treatment protocol, is generally non-compliant (with respect to treatment directives or office policies), does not follow up with appointments as recommended, or willfully disregards treatment objectives that are designed to obtain positive clinical outcomes. The providers will continue to treat the terminated patient on an *emergency basis only* for 30 days after termination.

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PHYSICIAN-PATIENT AGREEMENT

STORAGE, TRANSFER & ACCESS TO PATIENT RECORDS ON TERMINATION OF THE PRACTICE:

In the event of the termination of Caplan & Associates, LLC practice, the providers or their designee will advise all active clients (by letter or direct verbal communication) where and how they may contact the doctor for purposes of interim/transfer care or to request a transfer of their records to the next physician. Patients will be provided either a phone number to contact the doctor directly or with numbers for the Arizona State Medical Board, who will be able to properly direct requests (the doctor will maintain current contact with the association during the required period for records retention). The doctor will maintain a professional telephone contact number for a period of three to six months, depending on circumstances surrounding the closure of the practice.

The doctor or her designee will respond in a timely manner to patient requests for transfer of their medical records. Unless prohibited by illness, temporary travel unavailability, or death the doctor will respond within 30 days or other legally or ethically mandated timeframe. The doctor or her designee will dispose of unclaimed records after the legally specified time for retention by destroying said records such no confidential information remains in useable form.

In the event that circumstances require, the doctor or her designee will forward access and responsibility to another professional who will respond to records requests in accordance with legal and professional standards as set forth by the Arizona State Psychiatric Association and the Arizona State Medical Board.

I have read, understand, and accept the provisions of this Physician-Patient Agreement, and have no questions about the policies outlined herein. I understand that if I violate any provisions of this agreement my treatment may be terminated. I understand that this agreement is binding in the state of Arizona and that the provisions herein are for my protection and the protection of Dr. Caplan. The original, signed agreement will become part of my private medical record and I am entitled to a copy at my request.

____
Print Patient Name   Date of Birth

____
Patient signature   Date
(or responsible party if a minor)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,____ acknowledge that I have been provided a copy of
(Print patient name *and* responsible party if a minor) Caplan & Associates, LLC's **Notice of Privacy Practices.**

This notice describes how Caplan & Associates, LLC and its providers may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Additionally, as a psychiatric practice, the material contained within the medical record may be sensitive. As it could affect the well-being of the patient, or relationships within the family, medical records will be provided during an in-office session time, so that the provider and patient (and/or guardian if a minor) are able to read through them together before providing a copy.

____
Patient signature (or responsible party if a minor) Date of Birth Date

____
Full Name Relationship to Patient

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Prescriptions
For prescription refills, please allow at least 48 hours to have them called in. Depending on the date of your last visit, you may be required to schedule a consultation with a provider of Caplan & Associates, LLC to obtain a refill.

Insurance
The practice of Caplan & Associates, LLC *does not* participate with any health insurance plans. All visits are strictly fee for service, with no claim filing or pre-authorization/certification courtesies provided by the office.

An itemized invoice and paid receipt will be provided for each service which the patient or responsible party may use to file a claim with the patient's health insurance plan. Please check with your health plan to determine their policies on reimbursement of medical claims with out-of-network providers.

Appointments
A credit card will be required to hold an initial consultation / evaluation. There is a 24-hour cancellation policy for all appointments. If the patient does not appear for an appointment (no-show) or does not cancel at least 24 hours prior to appointment date/time by calling the office at: 602-324-4622, 50% fee for the type of session scheduled will be charged to the credit card.

Due to the scheduling of other patients, the provider cannot exceed your scheduled time if you are late.

Fees for Dr. Jane Caplan, MD	Fees for Charissa Lopez, PMHNP-BC
Initial evaluation 90-minute $600 60-minute $500	90-minute $500 60-minute $400
Subsequent visit 55-minute $400 25-minute $250	55-minute $300 25-minute $200

Sessions that extend above noted times may incur additional charges. Above fees as of 2019. All payments for services rendered are due at the time of service, unless arranged otherwise with Dr. Caplan, and Charissa Lopez. Payment methods accepted: cash, Zelle bank transfer at: jcaplanmd@me.com, Visa, MasterCard, and personal check payable to: Caplan & Associates, LLC.

____

Print patient's name | Date of Birth | Date

____

Patient Signature (or responsible party if a minor) | Relationship to patient

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RELEASE OF MEDICAL / MENTAL HEALTH INFORMATION AUTHORIZATION

I, (parent/guardian if minor) ____, hereby authorize Jane Caplan's office to obtain and release clinical information related to (patient name)____________________________________(date of birth)_____________ healthcare, including but not exclusive to mental health information, psychiatric and other medications, HIV status, and drug and alcohol abuse. Clinical communication includes, but is not limited to, verbal communication, clinical documentation, discharge summaries, testing and laboratory reports and any other clinically relevant materials.

Pediatrician/PCP Information	
Pediatrician/PCP Name:	Phone:
Email:	Fax:
Office Address:	City:
State:	Zip Code:

Psychiatrist Information	
Pediatrician/PCP Name:	Phone:
Email:	Fax:
Office Address:	City:
State:	Zip Code:

Therapist Information	
Pediatrician/PCP Name:	Phone:
Email:	Fax:
Office Address:	City:
State:	Zip Code:

Other	
Name:	Phone:
Email:	Fax:
Office Address:	City:
State:	Zip Code:

I understand why this information is needed and I am satisfied that it will be held confidential. Photocopies of this form will be considered as valid as the original. This authorization will remain in effect until revoked by me in writing. Any exclusions to the above are noted below:

Exclusion Notes:

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Credit Card Payment Authorization Form

Schedule your payments to be automatically charged to your credit card.
Just complete and sign this form.

Here's How Automatic Payments Work:

You authorize scheduled charges to your credit or debit card. You will be charged after each session- for that session only. **If you cancel an appointment without 24- hour notice, or if you do not show for an appointment, you will also be charged your session fee.** A receipt and an itemized invoice will be emailed, and the charge will appear on your credit card statement or, for debit card payments, in your bank account's transaction activity ledger. You agree that no prior-notification will be provided when your standard fee is charged for a session, no-show, or late-cancellation. **Your card will never be charged payments outside of the scope of this agreement without prior notification and your consent.**

Please Complete The Information Below:

Patient Full Name:____
(if different from cardholder)

I ____(Full Name)
authorize **Caplan & Associates, LLC** to charge my credit or debit card following each session, or per the office policy regarding late-cancellations and missed appointments.

Credit Card Information			
Card Holder Name (As it Appears On Card):			
Account Type: ☐ Visa	☐ MasterCard	☐ Amex ☐ Discover	☐ Other
Card Number:		Expiration Date (mm/yy)	CCV *:
Billing Address:		City:	
State:	Zip Code:	Phone:	
Email (Invoices will be sent here) :			

*CVV (3-digit number on back of Visa/MC, 4 digits on front of AMEX)

SIGNATURE:______________________________ DATE ____________________

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

For any Billing questions please call/text 480-717-1875 or email JEC-AR100@protonmail.com
our Billing Department directly