CHANDLER PSYCHIATRY PLLC

FARKHANDA KHAN MD
ADULT CHILD & ADOLESCENT AND
GERIATRIC PSYCHIATRIST

THERE WILL BE A CHARGE FOR
APPOINTMENT CANCELLED
WITH LESS THAN 24 HR NOTICE

3195 SOUTH PRICE ROAD
UNIT #150
CHANDLER AZ 85248

PH: 480-722-0239
FAX: 480-722-0240

PATIENT IDENTIFICATION FORM

Name:_____ Today's Date:_____
Last First Middle Initial

Current Address: _____
Street

_____
City State Zip Code

Telephone Numbers
(H): ( )_____
(W): ( )_____
(C): ( )_____
(Pgr): ( )_____

Permanent Address:_____
Street

_____ (Email):_____
City State Zip Code

Reason for Referral: Referred By:

Sex:
( )Male
( )Female

Marital Status:
( )Separated ( )Widowed
( )Married ( )Single ( )Divorced

Date of Birth:_____

Age:_____

Patient's Occupation:_____ Employer:_____

Social Security #:_____/_____/_____ School:_____

Place of Birth:_____ Drivers's License Number:_____

Responsible Party:_____ Relationship:_____

Occupation:_____ Social Security #:_____/_____/_____

Address:_____ Driver's License Number:_____
Street

_____ Telephone #: (_____)_____
City State Zip Code

Employer:_____ Telephone #: ( )_____

Employer Address:_____
Street City State Zip Code

Please Sign Below:

_____ _____
Patient Date

_____ _____
Responsible Party (if not patient) Relationship to Patient Date

_____ _____
Witness Date

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SUITE 111
CHANDLER AZ 85248

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HIPAA PRIVACY POLICY ACKNOWLEDGEMENT/AGREEMENT

This notice describes how your health information, as a patient of **Psychiatric and Psychological Affiliates of Scottsdale, PLC** may be used and disclosed, as well as how you can get access to your health information. This is required by the Privacy Regulations created as a result of the **"Health Insurance Portability and Accountability Act" of 1996 (HIPAA)**.

Our Commitment to your privacy: Your Clinician is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

Use and disclosure of your health information in certain special circumstances: (The following circumstances may require your clinician to use or disclose your health information.)

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. **IF** required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat and protect from harm.
5. If you are a member of the U.S. or a foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
8. For Workers Compensations and similar programs.

Your rights regarding your health information:

1. Communications: You can request that your clinician communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you including patient medical record and billing records, but not including psychotherapy notes. You must submit your request in writing to your clinician at: **3195 South Price Road, Unit #150, Chandler, AZ 85248**
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept for your clinician. To request an amendment, your request must be made in writing and submitted to your clinician at: **3195 South Price Road, Unit #150, Chandler, AZ 85248**
5. Filing a Grievance: You have the right to file a complaint. If you believe that your privacy rights have been violated, you may file a complaint with your clinician or with the Secretary of the Department of Health and Human Services. To file a complaint with your clinician, please submit in writing to your clinician at: **3195 South Price Road, Unit #150, Chandler, AZ 85248** . Please note, you will not be penalized for filing a complaint.
6. Right to a copy of this notice at any time: You are entitled to receive a copy of this Notice of Privacy Policies. You may ask us to give you a copy at any time. To obtain a copy of this notice, contact your clinician's front reception desk.
7. Right to provide an authorization for other uses and disclosures: Your clinician will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our Health Information Privacy Policies, please contact your physician/clinician at **(480) 722-0259**.

Please, sign the second page of this Privacy Policy to acknowledge your receipt of this information.

Thank you, Psychiatric and Psychological Affiliates of Scottsdale, PLC

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY (HIPAA) AGREEMENT

I, _____, acknowledge that I have received a copy of the Chandler Psychiatry PLLC "HIPAA Privacy Policy Acknowledgement Agreement" form.

This notice describes how Chandler Psychiatry PLLC 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.

_____ _____
Patient **Date**

_____ _____
Patient Representative **Date**

_____
Relationship to Patient

_____ _____
Witness **Date**

CHANDLER PSYCHIATRY PLLC

Verbal Disclosure Authorization

I do hereby request and authorize **Chandler Psychiatry PLLC** health care staff, clinician(s), and physician(s) to be able to contact the following people or organizations for the purpose of: “Facilitation of Treatment.”

Names and relationships of who may be contacted are: **Additions/Deletions**

Parent/Guardian	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Parent/Guardian	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Physician	Phone	Date	Parent Initials	Patient Initials	Staff Initials
School Counselor	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Psychologist/Therapist	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Psychiatrist	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Family/Significant Other	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Probation/Parole/Pretrial Officer	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Other	Phone	Date	Parent Initials	Patient Initials	Staff Initials
Other	Phone	Date	Parent Initials	Patient Initials	Staff Initials

I understand that the verbal exchange of information may include reference to diagnostic impressions and/or treatment of alcohol/drug use and emotional illness. I understand that my consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon. This consent will remain in effect for 12 months from the date of signatures below.

The information disclosed to the authorized parties is from treatment which confidentiality is protected by Federal Law. The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** regulations prohibit further disclosure of this information without specific written consent of the person to whom it pertains.

Patient Signature (Patients 14 yrs or older must sign)	Date	Initials
Parent/Guardian Signature	Date	Initials

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Medical Records Release

Name:_____ DOB:_____ Phone:_____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization:

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax

PLEASE SEND INFORMATION TO:

Farkhanda Khan, MD
3195 South Price Road Unit #150
Chandler, AZ 85248

Phone: (480) 722-0239
Fax: (480) 722-0240

I AUTHORIZE the following information to be disclosed: (Please Initial all that apply)

_____Entire Record _____HIV Record _____Billing Records

_____Immunization Record _____STD Record _____Sleep Study

_____Lab Tests _____Psychiatric/Mental Health _____Other

_____TB Tests _____Alcohol/Substance Abuse _____

_____ Neuro Imaging Studies _____EKG

REASON for disclosing health information

_____At my request

_____Continuing Care

_____Insurance

_____Other (Please specify)_____

EXPIRATIONS of this Authorization

_____ 1 Year after signature date _____ On this date:_____

ADDITIONAL PATIENT INFORMATION:

•I understand that I have the right to withdraw this authorization.
•I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected by Chandler Psychiatry, PLLC.
•I understand that signing this authorization does not cancel any rights I have under state or federal laws.

Patient Signature_____Date_____