WELL BEING SYSTEMS, PLLC
HEALTHCARE PROVIDER- PATIENT SERVICES AGREEMENT

Patient Name: _____ Date of Birth: _____

Welcome, I am pleased you have chosen us as your healthcare provider. Please read the following document carefully as it contains important information about our professional services and practice policies.

MEDICATION SERVICES
Your treatment may include taking medication. There are wide varieties of medications available for sleep or sleepiness problems as well as for mental health problems such as depression or other mood disorders like bipolar disorder, anxiety, posttraumatic stress disorder, psychotic disorders and others. Prescribing of medication must take into account your personal medical history, other medications that you take, allergies to medicines or other products and your treatment goals. When I recommend a medication prescription for you, I will inform you of significant benefits and risks, answer any of your questions to the best of my ability and advise you about appropriate regular monitoring of your use of medication, including any necessary periodic laboratory tests.

_____ Initial Here

CONTACTING ME
Due to my work schedule, I am not immediately available by telephone. Telephones are answered by office staff or our answering service. Every effort will be made to return your call promptly, either by your provider or the office staff, during business hours. After hours emergencies will be returned by the on-call provider. If you are unable to reach us during normal business hours, and feel you cannot wait for a return call, contact 911 or go to the nearest emergency room.

_____ Initial Here

LEGAL LIMITS ON CONFIDENTIALITY PROTECTIONS
The law protects the privacy of all communications between a patient and a healthcare provider. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Information Portability and Accountability Act (HIPAA). There are other situations that require only written, advance consent. However, there are some situations in which I am permitted or required to disclose information without either your consent or Authorization. These situations are primarily related to danger to yourself or to others and child or elder abuse or neglect. If such situations arise, I will make every effort to discuss them with you before taking any action and I will limit my disclosure to what is necessary. For details on the limits of your confidentiality required by law, please refer to my office form entitled, "Notice of Healthcare Providers Polices and Practices to Protect the Privacy of your Health Information," especially Section 11 ("Uses and Disclosures Requiring Authorization") and Section Ill ("Uses and Disclosures with Neither Consent nor Authorization"). Your signature on this Agreement

provides consent for those activities. While this written summary of exceptions of confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and I do not give legal advice. In situations where specific advice is required, formal legal advice may be needed.

_____ Initial Here

MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, it is sometimes my policy to request an agreement from parents that they consent to give up or suspend their access to their child's records. If they agree, during treatment I will provide them only with general information about the progress of the child's treatment, unless the child agrees otherwise. Before giving parents any information that the child expects to be confidential, I will discuss the matter with the child, if possible, and do my best to handle any objections. Important exceptions to this confidentiality procedure involve any issue or potential issues regarding matters of the child's safety. I will ensure that parents are rapidly informed about any safety concerns that come to my attention. This may be done by promptly scheduling a joint session to be attended by both child and parents so that the child can inform the parents of the safety issue himself or herself in the context of the support offered in a therapy session. Alternatively, if the child is not able to agree to a joint meeting for any reason or if the safety concern is urgent, I may telephone one or both parents to quickly discuss the relevant safety concern. Parents should feel free to clarify this policy or request modification to it at any time they become aware of a safety concern for their child.

_____ Initial Here

PROFESSIONAL RECORDS

You should be aware that, pursuant to the Health Information Portability and Accountability Act (HIPAA), I keep Protected Health Information (PHI) about you in two sets of professional records. Please refer to the "Notice of Healthcare Provider's Policies and Practices to Protect the Privacy of Your Health Information," for more information regarding the above.

_____ Initial Here

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protect Health Information (PHI). These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form and my privacy policies and procedures. I am happy to discuss any of these rights with you.

_____ Initial Here

CONSENT FOR TREATMENT AND CONSULTATION

I authorize and request that Well Being System's Providers, carry out behavioral health treatments, and/or diagnostic procedures that now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE MAY RECEIVE ADDITIONAL HIPAA INFORMATION DESCRIBED ABOVE, UPON REQUEST.

_____

Patient (Authorized Parent/Guardian) Print Name

_____ _____

Patient (Authorized Parent/Guardian) Signature Date

ALVIN C. BURSTEIN, M.D.
8687 East Via De Ventura, Suite 318 Scottsdale, AZ 85258
Tel: 480-905-8755; Fax: 480-905-8851

Financial Agreement

Billing for Services

Fees for services are determined by the provider and payment is due at the time services are rendered. Parents/Guardians are financially responsible for payment for services provided to minors or legal dependents. Fees may include other professional or administrative charges, not limited to:

- Report writing
- Records Preparation
- Psychological testing
- Telephone conversations
- Bounced check fee $35
- IME services
- Consulting with other professionals
- Finance/collection fees
- Legal proceedings

Claims will be submitted on your behalf if you have insurance that is in-network. It is your responsibility to know your insurance benefits and to obtain any required authorization or referral. You are responsible for fully disclosing accurate and complete insurance information, including insurance changes, **in advance** of your scheduled appointment. You will be considered Self-Pay if you have no insurance, have out-of-network insurance, or have not provided verifiable insurance information. Claims will not be submitted retroactively if the necessary information is not provided in a timely manner.

Copays, Deductibles, Co-insurance amounts, or Self-Pay services are due at the time the services are rendered. You agree to maintain an active Card Authorization on file that may be charged for services rendered. Fees for Services and Procedure Codes billed may fluctuate and are determined by the provider based on services performed at that visit. You may be responsible for more or less than the amount estimated or collected once processed.

If services are denied by your insurance, or if the service is unpaid by insurance after 90 days, you will be billed the full fee for the services. Prompt payment is expected for account balances. Your balance may be charged to your card on file with or without advance notification at the discretion of the provider or financial manager. If the amount due is substantially higher than previously expected, the office will attempt to notify you of the balance and/or upcoming payments that will be charged to your card on file. If we do not hear from you or are otherwise unsuccessful at reaching you, your card may be charged for the full or partial amounts.

If you need to make alternative payment arrangements for an upcoming appointment, or would like to establish a payment plan, please contact the financial manager right away. Regular payments must be made toward your balance to prevent your account from becoming delinquent. Delinquent account balances older than 90 days may accrue finance charges or be subject to further collection action.

Policy for Missed Appointments and Cancellations

Appointment times are reserved exclusively for you. The office must be notified at least 24 hours in advance to cancel or change your appointment. Missed appointments or late cancellations will be charged the **FULL FEE** for the scheduled service. If you have had a fever, cough, or symptoms of any illness within 10 days of or on the day of your office visit, please contact the office to reschedule free of charge.

For questions, please contact 480-905-8755 Office or 480-905-8755 x 203 Billing.

BY SIGNING THIS FINANCIAL AGREEMENT, I HAVE READ ALL ITEMS AND ACCEPT THE TERMS:

_____
Patient or (Authorized Parent/Guardian Name) **Printed**

_____ _____
Patient or Authorized Parent/Guardian Signature Date

ALVIN C. BURSTEIN, M.D.
8687 East Via De Ventura, Suite 318 Scottsdale, AZ 85258
Tel: 480-905-8755; Fax: 480-905-8851

Credit Card Authorization Agreement

Our office will always hold your appointment times for you in the schedule, and in return requests that you fill out this form. This form authorizes our office to bill your credit card for services and missed sessions. It is kept confidential and private. As a reminder, your insurance company will not reimburse you for missed sessions or late cancellations. Appointments must be canceled within 24 business hours to avoid a fee.

Typical Fee for Services:
$350 Initial Evaluation
$100-$175 Routine Follow Up
$250 Extended Follow-Up
Reports/Other Services - Varies

I, the undersigned individual, authorize Well Being Systems, PLLC, to charge my credit card for all account balances, including:

- Missed appointments or late cancellations, billed at the full rate of the scheduled appointment
- Outstanding payments for services rendered, including co-pays, deductibles, and co-insurances
- Fee for Self-Pay services, as determined by the provider
- Claims that have been denied or unpaid by your insurance after 90 days
- Any professional services not billable to insurance
- Reports and other account balances not stated above

Your card will automatically be charged without notification for routine patient responsible amounts. The office will attempt to notify you prior to charging your card if we feel the charges are higher than anticipated. If we do not hear from you or are otherwise unsuccessful at reaching you, your card may be charged for the full or partial amount at the discretion of the office. You agree to not dispute charges for any of these reasons. You further authorize our office to disclose information about my attendance and/or cancellation to your credit card company if you dispute a charge.

If you would like to use an HSA card, please provide a secondary source of payment in the case of depleted funds or services other than appointments.

Card #: _____ HSA? ____

Expiration: _____ Security code: _____

Card #: _____ HSA? ____

Expiration: _____ Security code: _____

Cardholder Name (as printed): _____

Name of patient: _____

Billing Address: _____Zip:_____

Signature: _____ _____
(Patient or financially responsible party) Date

PATIENT CONSENT FOR ELECTRONIC BILLING COMMUNICATIONS
WELL BEING SYSTEMS, PLLC

The purpose of the following form is to request electronic billing communications be sent to the E-mail address provided. This includes:

Billing Statements - Payment Receipts - Billing-Related Correspondence

** Please note: Email correspondence is **NOT** for refills or clinical questions. Direct messaging for clinical requests is available through our secure **PATIENT PORTAL.** ** If you need to cancel or change an appointment, you MUST call the office. Email requests may not be accepted. **

Consent and Acknowledgement

I, _____, would like to receive electronic billing communications. I understand that *WELL BEING SYSTEMS PLLC* cannot guarantee the security and confidentiality of any e-mail transmission due to common risk factors.

Common risks associated with electronic communication include, but are not limited to:

- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can also be circulated, forwarded and stored in paper and electronic files.
- Risk of unauthorized view by a third party (Shared email, Employer, etc)
- Email senders can easily misaddress an email

By signing this consent, I acknowledge the risks above and agree to have electronic billing communications sent to the E-Mail address listed below. I understand that e-mail may be unencrypted. This consent may be revoked at any time by advising *WELL BEING SYSTEMS PLLC* in writing.

Patient Name: _____ Date of Birth: _____

E-Mail Address: _____

PLEASE PRINT YOUR EMAIL ADDRESS CLEARLY

Signature of Patient: _____Date: _____

WELL BEING SYSTEMS, PLLC
PATIENT – CLIENT INFORMATION

LEGAL Name_____ Date of Birth_____
(must match insurance card)

Address_____ City_____ State_____ Zip_____

Mailing Address_____ City_____ State _____ Zip_____
(If different)

Phone: Cell _____ Home _____
Appt. reminders are text, voice and email

Email: _____

Person responsible for your account _____ Relationship_____

Ethnicity: Hispanic_____ Non-Hispanic_____ I choose not to answer_____

Preferred language:_____

Relationship status: Single Married Partnered Divorced Widowed

Name of Spouse/Partner (parents/guardian for minor)_____

Children & Ages (siblings for minor) _____

I GIVE PERMISSION FOR DR BURSTEIN TO RELEASE AND/OR RECEIVE MEDICAL OR FINANCIAL INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION, TO THE FOLLOWING PEOPLE, NOT INCLUDING HEALTH CARE PROVIDERS: (***OPTIONAL***)

NAME _____ RELATIONSHIP_____ Patient Initials _____

NAME _____ RELATIONSHIP_____ Patient Initials _____

Please note: Separate authorization form needed to release/receive information from health care providers. This form will be given upon request.

Name of referring physician _____

In case of emergency notify _____ Relationship_____Phone_____

REFERRED BY – IF OTHER THAN YOUR DOCTOR_____

Please explain why you are seeking help at this time:

_____

_____

Please explain how your problems are affecting your work and relationships, plus your general functioning:

_____

_____

_____

_____

 Patient name_____ Date of Birth_____

On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now: _____

Please check any health problems you have or have had:

_____lung	_____high blood pressure	_____arthritis
_____liver	_____diabetes	_____other pain
_____kidney	_____seizures	_____cancer
_____stomach/intestinal	_____head injury	

Medicines you are allergic to: _____

Medicines you now take:

_____
_____
_____
_____
_____

How much and what kind of exercise you get: _____

Height _____ Weight _____

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

___ Physical health
___ Chronic Pain
___ Low mood
___ Mood swings
___ Energy/motivation level
___ Memory
___ Concentration
___ Sleep
___ Sexual functioning
___ Suicidal thoughts
___ Spirituality/religion
___ Marriage/relationship
___ Family conflicts

___ In-law problems
___ Job or school performance
___ Friendships
___ Financial problems
___ Obsessions (unwanted thoughts)
___ Nightmares
___ Thoughts of hurting someone
___ Compulsions (unwanted actions)
___ Flashbacks
___ Paranoid thoughts
___ Domestic violence (verbal)
___ Domestic violence (physical)
___ Drinking alcohol

___ Using drugs
___ Panic Attacks
___ Phobias
___ Anxiety symptoms
___ *sweating*
___ *short of breath*
___ *stomach upset*
___ *dizziness*
___ *choking*
___ *racing heart*
___ *weakness*
___ *dry mouth*
___ *feeling trapped*
___ *panic*

SUBSTANCE USE	Average amount Past 2 months	Most ever used
Coffee	_____	_____
Cigarettes	_____	_____
Alcohol	_____	_____
Recreational Drugs	_____	_____

 Patient Name _____ Date of Birth_____

For the following, please circle YES or NO and give details:

Have you had counseling or psychotherapy in the past? YES – NO _____
Have you ever taken medication for your emotional or mental health? YES – NO _____
Have you ever been hospitalized for psychiatric problems? YES – NO _____
Have you ever been arrested? YES – NO _____
Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES – NO
_____
Have you ever had any experiences that you would consider traumatic or abusive? YES – NO
_____
Have you ever tried to kill yourself or hurt yourself in any way? YES – NO _____
Is there any danger these days that you might hurt yourself or someone else? YES – NO _____

Please describe your education:
_____

Please describe the family you grew up in including your parents and names and ages of your siblings:
_____
_____
_____
_____

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:
_____
_____
_____
_____

Please describe your support system (family you are close to, friends you talk with, etc.):
_____
_____

What is your current job and how do you like it?
_____
_____
_____

SLEEP QUESTIONNAIRE – PLEASE COMPLETE IF YOU HAVE A SLEEP PROBLEM

Name_____ Date of Birth_____

What is the main problem with your sleep? _____
Are you a shift worker? **YES** or **NO** If so, what hours do you work? _____
On average, how many hours of sleep do you get in 24 hours? _____
All at once or with naps? _____ Is this enough? **YES** **NO** Or too much? **YES** **NO**

INSOMNIA - POOR SLEEP QUALITY

Do you have problems getting to sleep or staying asleep? **YES** **NO**
If so, is your main problem getting to sleep, or waking up too much, or both? _____
Do you tend to sleep at the wrong time; that is, are you an extreme night owl or morning lark? **YES** **NO**
If so, what is your best window of time for sleeping? _____
Do you legs or arms itch, burn, tingle or just feel "fidgety" when you are trying to sleep? **YES** **NO**

EXCESSIVE SLEEP OR SLEEPINESS

Are you often too sleepy when you need to be awake? **YES** **NO**

On your usual schedule in recent weeks or months, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to answer according to how you think they might affect you. Choose the most appropriate number for each situation:

0 = would never doze **1 = slight chance of dozing** **2 = moderate chance** **3 = high chance of dozing**

Sitting & reading	0 1 2 3
Watching TV	0 1 2 3
Sitting in a public place, like a waiting room	0 1 2 3
Riding in a car for 1 hour	0 1 2 3
Lying down to rest	0 1 2 3
Sitting & talking	0 1 2 3
Sitting after lunch without alcohol	0 1 2 3
Driving a care while stopped in traffic	0 1 2 3
Total Score	_____

The Epworth Sleepiness Scale
(John, M.W. (1993) Chest 103:30-36)

Other situations in which you fall asleep when you don't mean to? _____

Do you snore? **YES** **NO** Loudly enough to disturb others? **YES** **NO** Stop Breathing? **YES** **NO**

SLEEP BEHAVIORS and OTHER PROBLEMS

Do your legs or arms twitch or jerk during sleep? **YES** **NO** Whole body? **YES** **NO**
If either, do these twitches or jerks seem to interfere with your sleep? **YES** **NO**
Do you sleepwalk or act out dreams: **YES** **NO**
Do you fall out of bed or have unusual movements during sleep? **YES** **NO**
Have you ever injured yourself or someone else while asleep? **YES** **NO**
Do you have nightmares? **YES** **NO**

MOOD DISORDER QUESTIONNAIRE

Patient Name _____ **Date of Birth** _____

Has there ever been a period of time when you were not your usual self and

You felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	yes	no
You were so irritable that you shouted at people or started fights or arguments?	yes	no
You felt much more self-confident than usual?	yes	no
You got much less sleep than usual and found you didn't miss it?	yes	no
You were much more talkative or spoke much faster than usual?	yes	no
Thoughts raced through your head or you couldn't slow down your mind?	yes	no
You were so easily distracted by things around you that you had trouble concentrating or staying on track?	yes	no
You had much more energy than usual?	yes	no
You were much more active or did many things more than usual?	yes	no
You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	yes	no
You were much more interested in sex than usual?	yes	no
You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	yes	no
Spending money got you or your family into trouble?	yes	no

If you circled YES to more than one of the above, have several of these ever happened during the same period of time?	yes	no

How much of a problem did any of these cause you – like being able to work; having family, money or legal troubles, getting into arguments or fights?

No Problem Minor Problem Moderate Problem Serious Problem

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE PHQ-9

Patient Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	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**
☐	☐	☐	☐