Richard Gottlieb, M.D., Psy.D.
Psychiatry and Psychoanalysis

**PLEASE READ, SIGN, AND DATE THE FOLLOWING PAGES AND RETURN TO THE OFFICE:**

## PATIENT INFORMATION

NAME:_____ M: [ ] S: [ ] D: [ ] W: [ ]

ADDRESS: _____ M: [ ] F: [ ]

CITY: _____ STATE: _____ ZIPCODE: _____

DOB: _____/_____/_____ AGE: _____ SS#:_____-_____-_____

HOME #:( _____ ) _____ - _____ CELL #:( _____ ) _____ - _____

EMPLOYER_____ WORK# (_____)_____-_____

## INSURED INFORMATION

NAME: _____ RELATIONSHIP_____

ADDRESS: _____ M: [ ] F: [ ]

CITY: _____ STATE:_____ ZIPCODE: _____

DOB: _____/_____/_____ AGE: _____ SS#: _____ - _____ - _____

HOME #: ( _____ ) _____ - _____ CELL #: ( _____ ) _____ - _____

EMPLOYER_____ WORK# (_____)_____-_____

## INSURANCE INFORMATION

INSURANCE CO:_____ PHONE # (_____)_____-_____

ID#_____ GROUP #_____

AUTHORIZATION #_____ DATE OBTAINED:_____

(**IF YOUR INSURANCE COMPANY REQUIRES AUTHORIZATION AND YOU DID NOT OBTAIN ONE YOU WILL BE RESPONSIBLE FOR PAYMENT**)

## EMERGENCY CONTACT

NAME:_____PHONE #_____RELATIONSHIP_____

TODAY'S DATE: _____/_____/_____ SIGNED: _____

# GENERAL CONSENT TO TREAT

I, _____, hereby agree to allow Richard Gottlieb, MD, PsyD, to treat me with psychiatric medication, psychotherapy, or both. I understand that this consent is for out-patient treatment only, whether rendered in an office or via telehealth. I understand that after I am evaluated by Dr. Gottlieb, he may recommend treatment options that include psychotherapy, psychiatric medication(s), or both. Should medical or psychological tests be required to make a definitive diagnosis before medically necessary treatment can be recommended, I understand that Dr. Gottlieb will either perform those tests himself or will refer me to a laboratory or specialist to perform them.

I hereby agree to inform Dr. Gottlieb of any objections I have against following his medical advice. Should I refuse any of the recommended treatments or diagnostic tests, Dr. Gottlieb will offer alternative treatments or tests if possible. Should in Dr. Gottlieb's opinion no reasonable alternatives exist and should I still refuse the recommended treatment or tests, I understand that Dr. Gottlieb may choose to close my case. Should he decide to close my case, I understand that Dr. Gottlieb will try to assist me to find another competent psychiatrist or mental health professional who may accept my case.

I understand that Dr. Gottlieb desires to permit the maximum amount of freedom possible in the doctor-patient relationship. However, I also understand that occasionally there are extraordinary circumstances wherein Dr. Gottlieb may need to intervene on my behalf. Examples include the development of serious suicidal or homicidal feelings, or psychotic symptoms such as hearing voices or feeling paranoid. Therefore, I hereby agree to report any suicidal or homicidal feelings and/or unusual thoughts I have to Dr. Gottlieb as soon as possible. Should my symptoms intensify to the point that I feel unable to prevent myself from acting on them, I hereby agree to immediately call 911, Dr. Gottlieb, or any doctor who is on call for him. I further understand that Dr. Gottlieb or his on-call doctor may require that I enter a psychiatric hospital at that time for my own protection or for the protection of others.

Should I refuse psychiatric hospitalization as recommended for any reason and should Dr. Gottlieb or his on-call doctor feel outpatient treatment can no longer be safely rendered for any reason, I understand that Dr. Gottlieb or his on-call doctor may contact the public mental health authority and/or the local police department to institute an involuntary hospitalization. Should I choose to act on suicidal or homicidal feelings without first reporting them or should I refuse voluntary hospitalization as recommended, I understand that I will have violated this consent and that Dr. Gottlieb may choose to withdraw his services or refer me to another psychiatrist.

I understand that I am responsible for promptly paying all fees incurred by me for any treatment services rendered by Dr. Gottlieb to me, or to any person for whom I am financially responsible. I understand that upon request I will be given a complete accounting of all charges incurred and/or billed to my insurance company. I understand that if Dr. Gottlieb agrees to bill my insurance company for any services he renders to me, it remains my responsibility to make sure that my portion of the bill is promptly paid. Should the insurance company request information from me before it agrees to pay its portion of Dr. Gottlieb's bill, I agree to promptly provide that information. I understand that failure to provide the requested information may result in the insurance company denying the claim and that in that case I will be required to pay the bill in full myself. If for any reason any portion of Dr. Gottlieb's bill is not paid by my insurance company, I agree to pay in full the remaining balance. If my insurance company pays me instead of paying Dr. Gottlieb directly, upon receipt of said payments I hereby agree to properly endorse the insurance checks and mail them to his office.

NOTICE TO PATIENTS: I understand that Dr. Gottlieb is licensed to practice medicine in both Arizona (License # 16089) and California (License # G-51369). Medical doctors are licensed and regulated in Arizona by the Arizona Medical Board, and in California by the Medical Board of California. To check up on a license or to file a complaint in Arizona go to https://www.bomex.org, email: questions@azmd.gov, or call 480-551-2700; in California go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322. You may also scan the QR codes listed below:

**ARIZONA MEDICAL BOARD**

**MEDICAL BOARD OF CALIFORNIA**

_____ _____

**Patient's Signature** **Date**

_____ _____

**Responsible Relative's Signature** **Date**

**GOOD FAITH ESTIMATE FOR HEALTH CARE SERVICES UNDER THE "NO SURPRISES ACT"**

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or who are not seeking to file a claim with their plan or coverage at the time of scheduling health care items and services. This includes patients who DO have health insurance that would pay for all or part of their treatment, but who DECLINE to use their insurance to pay for their treatment.

- **PATIENT NAME**: LAST _____ FIRST _____ MI ___
- **DATE OF BIRTH**: _____ / _____/ _____
- **SERVICE TYPES**: PSYCHIATRIC INTAKE (99205), MEDICATION MANAGEMEMT (99213 & 99214), SUPPORTIVE THERAPY or PSYCHOANALYTIC PSYCHOTHERAPY (90834), PSYCHOANALYSIS (90845)
- **FEE SCHEDULE**: 60 MIN INTAKE: $450, 25 MIN MED VISIT: $200, 15 MIN MED VISIT: $150, PSYCHOTHERAPY (BOTH SUPPORTIVE AND PSYCHOANALYTIC): $350, PSYCHOANALYSIS: $350
- **APPLICABLE DIAGNOSIS CODES**: To be determined pending evaluation for Mental Health and Substance Abuse problems
- **TREATING PSYCHIATRIST**: NAME: RICHARD GOTTLIEB MD, PSYD NPI: 1205891413 TIN: 86-0673647
- **EXPECTED SERVICES**: Dr. Gottlieb will do an initial psychiatric evaluation to determine a tentative diagnosis and to make treatment recommendations. If treatment with psychiatric medication(s) is indicated, he will need to see you in 15- or 25-minute follow-

up visits at a frequency and duration to be determined by the medication response and any side effects that need to be mitigated. A positive response to the medication(s) without a significant side effect burden can be expected to result in a visit frequency of no less than 1 15-minute visit every 1-3 months for a minimum duration of 6 months. Should long-term medication management be indicated and desired by the patient, the minimum number of visits per calendar year will be 2. Supportive psychotherapy (also called counseling) has no set frequency or duration, but usually patients are seen every 1-3 months for as long as necessary to help them cope with adverse life circumstances or to prevent a return of psychiatric symptoms. Psychoanalytic psychotherapy is a more intensive process designed to explore how patients have adapted to early life adverse circumstances and how those adaptations are causing psychiatric or psychological problems in the present day. A minimum frequency of one session per week for several months or years is required depending on the number of issues being addressed and their complexity, as well as patient preference. Psychoanalysis is similar to psychoanalytic psychotherapy but is an even more intensive process in which patient and analyst delve deeply into the patient's thoughts, feelings, and behaviors in context of the patient's backstory and relationship history. Patients are seen 3-5 times per week for several years, a frequency that is often necessary to create a thorough self-understanding and/or to change or mitigate stubborn problematic behaviors.

- **DISCLAIMERS**:
    - There may be additional items or services recommended that may arise from time to time as part of the course of care that are not reflected in this good faith estimate, such as fees for completing forms that you, your insurance company, or your employer needs completed, for missing appointments, for refilling medications in-between appointments, and for afterhours emergency phone calls.
    - The information provided in this good faith estimate is only an estimate and that actual items, services, or charges may differ from the good faith estimate.
    - You have the right to initiate a patient-provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate. You may initiate the dispute resolution process by calling my office at 480-477-7793 or by emailing us at intelliclinics@gmail.com. The initiation of a patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to you.
    - This good faith estimate is not a contract and does not require uninsured or self-pay individuals to obtain services from me.

## CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby agree to allow Dr. Gottlieb and his office assistants to contact the following individual or agency:

_____ _____ _____
Name Address Telephone

I understand the purpose is to exchange important information for diagnostic and/or therapeutic reasons. Information authorized to be exchanged includes only the following:

[ ] *Psychiatric hospital records*
[ ] *Psychological test results*
[ ] *Out-Patient treatment report*
[ ] *Educational record*
[ ] *Medical hospital records*
[ ] *Vocational test results*
[ ] *Laboratory test results*
[ ] *Other*: _____

I authorize the release of these materials to the individual or agency listed above [ ]
I authorize the individual or agency listed above to release these materials to my clinician [ ]

Date consent given: ___/___/___ Expires: ___/___/___

Print patient name_____

_____ _____
Patient or Legal Guardian Witness

==========

Consent revoked this _____ day of _____, 20 _____

_____ _____
Patient or Legal Guardian Witness

**I understand that my records are protected under Federal (42 CFR Part 2) and/or state confidentiality regulations. Upon revocation of authorization, further release of information shall cease immediately. File copy is equivalent to the original. This release of information expires in thirty (30) days following completion or termination of treatment, whichever is later. If information that is released relates to substance abuse treatment, these records confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit anyone who receives these records from any further disclosure of it without specific written consent to the person to whom it pertains. A general authorization for the release of medical information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records.**

# Policies and Procedures: Privacy Protection

**I.** General Policy

It is Dr. Gottlieb's policy to work diligently to protect the privacy of all his patients. Under most circumstances he shall release only the ***Minimum Necessary*** information when sharing ***Protected Health Information***, as defined by the Health Insurance Portability and Accountability Act (HIPAA). Information disclosed shall be categorized according to its sensitivity level. Only the lowest level of information required by requesting parties to meet their legitimate needs shall be released. Reasonable safeguards shall also be in place to prevent the incidental disclosure of protected information.

**II.** Protected Health Information

Protected Health Information is defined herein as personally identifiable medical and psychotherapy records maintained on patients as required by state and federal laws. Psychotherapy records shall have a higher level of privacy protection than medical records, shall be kept in a special section of the medical chart, and shall never be released without a signed authorization from the involved patient.

**III.** Who May Request Protected Health Information

Dr. Gottlieb will release protected health information only with his patients' written permission. He shall act in compliance with HIPAA regarding the release of Protected Health Information to all requesting parties, including the following:

**A.** The Patient

Under HIPAA, patients may now request copies of their medical records. Upon review, patients may also place an addendum in their files if they believe their records contain significant errors or omissions. Although patients have the right to request copies of their record, clinicians have the right to charge patients a reasonable fee to cover photocopying expenses. Finally, patients have the right to request a list of all parties who have to date requested a copy of their medical records.

**B.** The Patient's Family

Under HIPAA clinicians shall communicate with the patient's family only the minimum necessary information unless the patient specifically authorizes in writing more detailed disclosure.

**C.** Insurance Companies

Managed Care and Insurance Companies may request protected information to authorize payment of medically necessary treatment or to verify benefits. Dr. Gottlieb shall attempt to release the minimum necessary information to enable the successful completion of these tasks. However, should a dispute emerge between Dr. Gottlieb and these companies about what constitutes the minimum necessary information, Dr. Gottlieb shall inform his patients about the dispute and shall give his patients the right to refuse to release a higher level of protected information. In such a case patients shall be informed that their refusal may result in non-payment of services by their insurance company, and that they shall be responsible for paying Dr. Gottlieb his full private practice fees for their treatment.

**D.** Other Medical and Psychological Professionals

Medical and mental health professionals requesting protected information shall be asked to specify the minimum necessary information they require and shall be given the same.

**E.** Attorneys

Legal professionals requesting protected information shall be asked to specify the minimum necessary information they require and shall be given the same. Should Dr. Gottlieb receive a subpoena (a demand to respond) for protected medical information, Dr. Gottlieb will respond that he will not provide the records unless the patient waives the doctor-patient privilege and authorizes the release. However, he is required to give a timely response in order not to be in contempt of court. Thus, if patients do want him to release protected information to an attorney or court, they must also sign written authorization in a timely fashion. In such a case, Dr. Gottlieb may choose to close the patient's case and refer him or her to another psychiatrist if in his view it is problematic for the same psychiatrist to be both a treating physician and a legal witness. If patients choose not to waive the doctor-patient confidentiality privilege, Dr. Gottlieb will ask them to rescind in writing any previously signed consent and/or authorization forms, after which he will respond to the court that he is respectfully declining to release the information because the

patient has decided not to waive the privilege.

**F.** Business Associates

Clinicians' business associates requesting protected information shall be asked to specify the minimum necessary information they require and shall be given the same.

IV. Levels of Intentional Disclosure

Level 1: Dates of Service, Billing Information, and Name of Treating Clinician. Written consent needed.
Level 2: Level 1 Information, plus Diagnosis and Treatment Method(s). Written consent needed.
Level 3: Level 1 and Level 2 Information, plus Intake Evaluation and Medical Notes. Written consent needed.
Level 4: Levels 1, 2, & 3 Information plus Psychotherapy Notes. Both written consent and written authorization needed.

V. Incidental Disclosures

Incidental Disclosures are defined herein as unintentional disclosures that may naturally occur in the everyday practice of medicine and psychotherapy. Clinicians and office staff shall employ Reasonable Safeguards, as defined by HIPAA and as described below.

A. Waiting Room Procedures:

When possible, Dr. Gottlieb will motion for his next patient to leave the waiting room and enter his office without calling his or her name. If the patient does not make eye contact (i.e., because of reading), he will call out the patient's first name only.

B. Business Office Procedures:

The Business Office will remain locked during usual office hours unless it is staffed by an employee of Dr. Gottlieb. Patient charts shall remain in the locked business office or in direct sight of Dr. Gottlieb or his employee such that nobody but him or an employee of his shall have access to those charts. Other reasonable safeguards to protect patient privacy shall be employed. Filing Cabinets holding patient charts shall remain in the locked business office after hours and will also be protected by a monitored security system. Patient charts left on desks will be placed face down, with the patient's names concealed from view by other patients. Dr. Gottlieb and his office staff shall also follow special front office procedures as listed below:

1) Telephone Procedures:
   Dr. Gottlieb and his staff may leave messages for patients on answering machines and voice mails at phone numbers provided by patients. Reasonable safeguards to protect patient privacy when leaving messages shall be employed. Persons leaving messages shall leave the minimum necessary information such as name, preferred return call phone number and information authorized by the patient at intake to release when leaving phone messages.

2) Fax Procedures:
   All faxes containing protected health information shall be sent with a disclaimer notice regarding the confidentiality of the information being sent, in accordance with HIPAA regulations.

3) Marketing Procedures:
   No protected health information shall be used for marketing procedures by clinicians, office staff, or business associates, in compliance with HIPAA

By signing below, I hereby acknowledge that I have read, understand, and accept the above privacy protection policies and procedures as required by The Health Insurance Portability and Accountability Act (HIPAA).

_____ _____/_____/_____

Patient Date

_____ _____

Legal Guardian Witness

## MEDICARE OPT-OUT AFFADAVIT

This affidavit is made by RICHARD GOTTLIEB, M.D., a physician licensed to practice medicine in the State of Arizona and refers to treatment being rendered to _____, a Medicare beneficiary, hereinafter referred to as "Patient". The effective date of this agreement is ____/____/_____.

Except for emergency or urgent care services (s specified in Chapter 15 section 40 of the Medicare Benefit Policy Manual), during the opt out period Dr. Gottlieb will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §3044.8 for services that, but for their provision under a private contract, would have been Medicare covered services. The opt-out period is for a minimum of 2 years and Dr. Gottlieb will notify me of the end date of this opt-out period should he choose to accept Medicare in the future.

Dr. Gottlieb will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will he permit any entity acting on his behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in Chapter 15 section 40 of the Medicare Benefit Policy Manual.

During the opt-out period, Dr. Gottlieb understands that he may receive no direct or indirect Medicare Payment for services that he furnishes to Medicare beneficiaries with whom he has privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare or Medicare Advantage plan.

Dr. Gottlieb acknowledges that during the opt-out period, his services are not covered under Medicare and that no Medicare payment may be made to any entity for his services, directly or on a capitated basis.

Dr. Gottlieb acknowledges and agrees to be bound by the terms of both the affidavit and the private contracts that he entered during the opt-out period.

Dr. Gottlieb agrees not to submit a claim for payment under Medicare, even if such items and services would otherwise be covered by Medicare;

> That Medicare supplemental plans do not, and that other supplemental insurance plans may choose not to, make payment for items and services furnished by Dr. Gottlieb under the contract;
>
> That Patient is responsible for payment of such items or services;
>
> That no reimbursement will be provided by Medicare for such items and services;
>
> That Dr. Gottlieb is not limited in the amount he may charge me for items

and services provided;

That Patient has the right to have such items and services provided by other physicians who have not "opted out" of the program;

That Dr. Gottlieb will not submit any claim to Medicare for any item or service provided to any Medicare beneficiary during the minimum two-year period
beginning on the effective date of this agreement;

That Dr. Gottlieb will not receive any Medicare payment for any services provided to any Medicare beneficiary either directly or on a capitated basis;

Any addendum or change to this agreement shall be in writing and shall be signed by both Doctor and Patient.

_____ _____

**PATIENT** **DATE**

_____ _____

**DR. GOTTLIEB** **DATE**