Mark W. Imig, M.D., LLC
8124 E Cactus Rd. Suite 410
Scottsdale, AZ 85260 ph 602-297-5298 fax 602-494-3131
Private & Confidential

Today's Date _____

Patient's Name _____

Date of Birth _____-_____-_____ Age_____ Gender: M / F / Other: _____

Address_____

City, State, Zip_____

Home Telephone (_____) _____

Email _____

Cell Phone (_____)_____

If the patient is a minor, please fill out the following:

Mother's Name_____

Home Telephone (_____) _____Email_____

Cell Phone (____)_____

Address _____City, State, Zip _____

Marital Status: _____Married _____ Remarried _____Single _____Divorced _____Widowed _____Separated _____# of Years

Father's Name _____Home Telephone (_____) _____

Email_____ Cell Phone (_____) _____

Address _____ City, State, Zip _____

Marital Status: _____Married _____Remarried _____
Single _____Divorced _____Widowed _____Separated _____# of Years

Person to Contact in Case of Emergency:_____

Relationship_____Telephone (_____) _____

Other Telephone (_____)_____

Referred by_____

Phone number (_____)_____

Billing /Responsible Party Address (if different from above)

Name of Responsible Party_____

Address_____City_____State_____

Zip_____ Family Physician/Pediatrician _____

Phone number (_____)_____

Address_____City_____State_____

Zip_____

Office Policies

Dr. Imig does not participate with any health insurance plans. All visits are strictly fee for service, with no claim filing or pre-authorization/certification courtesies available. A “superbill”/receipt will be provided monthly which will provide the patient with the documentation needed to file a claim with their insurance plan. Some plans will reimburse partial payment for the services and some plans will not reimburse at all. Please check with your plan to determine their policies. All payments are due at the time of service. There is a 24 hour cancellation policy for appointments. The full session fee will be charged if not cancelled greater than or equal to 24 hours in advance. Due to the scheduling of other patients, I cannot exceed your scheduled time if you are late. For prescription refills, please allow at least 24 hours to have them called in. If you require scheduled (“controlled”) prescription refills, please allow 48-72 hours to have them submitted.

_____ _____

(Signature) (Date)

Patient Medical History

Current Medical Problems:

_____

_____

_____

Past Medical Problems or Surgeries:

_____

_____

_____

History of head injury: Y/N if yes, what year? _____

Allergies to Medications:

_____

Current Medications including medications you take everyday (include any meds you take as needed as well as any over-the-counter medications or supplements you take):

_____

_____

_____

Past Psychiatric Medications you have been treated with:

_____

_____

_____

_____ _____

(Signature) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received a copy of
(Name of Patient)

Mark W. Imig, MD's "Notice of Privacy Practices." This notice describes how Mark W. Imig, MD 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.

_____ _____
(Signature of Patient or Parent/Guardian if patient is less than 18 years old) (Date)

Consent for Email Communication

I, _____,
(Patient Name or Parent/Guardian Name and then relationship to patient if patient is less than 18 years old)

authorize use of email communication. Emails will only be read by Dr. Imig at mark@markimig.com. Emails are checked by Dr. Imig every 24-48 hours. Emails are considered to be a part of the medical record. Dr. Imig's email is not encrypted (Encryption alters emails using a secret code so that they are unintelligible to unauthorized parties).

Email communication has two functions: Administrative and Clinical.

Administrative: Emails can be used for appointment scheduling, prescription refills, billing questions, and contact information for referrals. Helen LaSonde provides billing statements and/or superbills for insurance reimbursement via email. Emails directed to Helen may be read by both Helen and Dr. Imig.

Please note that EMAIL IS NOT TO BE USED FOR EMERGENCIES.

Clinical: Any clinically relevant material in the email will be brought up in session. You may provide clinical information via email but Dr. Imig will not necessarily respond to clinical material via email and will instead bring it up at the next appointment so a thorough discussion about the material can occur. Work email addresses are not advised as employers have a right to access the computer system and psychiatric information may be exposed.

_____ _____

(Signature) (Date)

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I,_____,
(patient name or parent/guardian name if patient is a minor)

hereby authorize Dr. Mark W. Imig to obtain and release clinical information related to the patient's healthcare, including, but not exclusive to mental health information, psychiatric history, medications, HIV status, nicotine use, alcohol use, and drug use. Clinical communication includes, but is not limited to, verbal communication, clinical documentation, discharge summaries, testing and laboratory reports and any other clinically relevant materials.

PCP/Pediatrician_____ (_____)_____

Psychiatrist_____ (_____)_____

Therapist_____ (_____)_____

Other_____ (_____)_____

_____ (_____)_____

_____ (_____)_____

Regarding Patient:_____ Date of Birth: _____

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:
_____

_____

_____

Printed Name_____ Signature_____

Date_____

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I, (parent/guardian if minor)_____, hereby authorize Dr. Mark W. Imig to obtain and release clinical information related to the patient's 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.

_____ (_____)_____

_____ (_____)_____

Regarding Patient:_____

Date of Birth:_____

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:

_____

_____

_____

_____

Printed Name_____

Signature_____

Date_____