PARADIGM SHIFT THERAPIES, LLC

BASIC INTAKE DATA

(All info is self-reported by patient)

NAME____ Today's Date : ____________ REFERRED BY________________

MARITAL STATUS____________________________ BIRTH DATE _____________ AGE__________

M_____ F_____ Preference_____ ETHNICITY ____________ SEXUAL ORIENTATION: ___________

HEIGHT__________ WEIGHT____________ HAIR COLOR______________ EYE COLOR___________

ADDRESS____

CITY_________________________ STATE_______ ZIP___________ CELL PHONE:__________________

MAY WE LEAVE A DISCREET MESSAGE AT YOUR NUMBER? ____**YES** ____**NO**

NUMBER AND AGES OF CHILDREN____

CUSTODY of Child(s): ____**YES** ____**NO** **Acknowledgment** understanding PST does NOT provide Professional testimony in court for divorce or custody cases: ____________

INITIAL HERE

EMERGENCY CONTACT____

RELATION TO CONTACT_____________________________________PHONE______________________________

EMPLOYER__________________________________ TYPE of WORK ___________________________________

Acknowledgment understanding PST does provide professional FMLA documentation for an additional charge to counseling session, See financial agreement for pricing: ____________

INITIAL HERE

DO YOU HAVE HEALTH INSURANCE: ____**YES** ____**NO** TYPE__________________________________

DOCTOR'S NAME: ____ Dr's PHONE #:________________________

EDUCATION - HIGHEST GRADE COMPLETED_________________ REFERRED BY__________________________________

NUMBER OF TIMES IN TREATMENT_____________ YEAR(s) ________________

ARE YOU CURRENTLY ENROLLED IN ANY OTHER TYPE OF COUNSELING PROGRAM? ____**YES** ____**NO**

ARE YOU ON PROBATION / PAROLE / DRUG COURT / CRIMINAL JUSTICE SYSTEM? ____**YES** ____**NO**

Acknowledgment ~ I understanding PST will provide professional communication & documentation for an additional charge to counseling session, See financial agreement for pricing: __________

INITIAL HERE

REASON YOU ARE SEEKING SERVICES AT THIS TIME: ____

TYPE OF TREATMENT REQUESTING:

_____ Individual Therapy _____ Trauma Therapy ~ EMDR _____ Substance Abuse

____ ___________

Patient Signature DATE

UPDATED: 06/19/2021

PARADIGM SHIFT THERAPIES, LLC

CONSENT FOR TREATMENT

I hereby grant permission to Paradigm Shift Therapies, LLC (PST) to provide routine evaluation and treatment services as may be deemed necessary or advisable for the diagnosis and or care of me. I understand that this consent shall remain valid so long as I am enrolled in therapy or until I withdraw my consent. I understand that I must meet continued participation expectations (minimally meeting 1 time per month or as agreed), in order to maintain services. If I do not meet this minimum, I understand that I will receive a contact either by phone or written notice and will need to respond, or staff will consider this 'lack of contact' and your reason for discontinuation of treatment, resulting in closure of services.

I understand that all information gathered in the course of treatment is *confidential*. However, confidential information may be disclosed without my consent in accordance with state and federal laws (see confidentiality statement). Additionally, I understand that by signing this consent, I am giving permission for *Co-Mingled Records* (marriage counseling) to be managed as one file and there will be no secrets in conjoint therapy sessions ~ therefore, the therapist cannot be held liable for the disclosure of confidential information; furthermore, records maintained by PST will need to have both/all parties sign individual consents for the release of the contents of this one confidential file, even in legal requests. Finally, I authorize inter-agency staff (covering therapist or administrative support) access to PHI as it relates to my treatment.

I understand that the philosophy of care at PST includes the belief that people should be treated in the least restrictive environment and that PST staff do not provide any physical, mechanical, or chemical restraints. Staff is trained to intervene, when necessary, using nonphysical de-escalation techniques in an attempt to calm a situation to prevent harm. Staff will call the police if anyone is at risk for physical harm to self or others.

I agree to participate in my treatment planning process to the best of my ability, understanding that any significant change during my recovery treatment would require a treatment plan update. I also understand that PST will incorporate the following in the treatment program:

- Recovery Model: *PST utilizes a Solution Focus therapeutic modality, Rational Emotive Behavior Therapy for Cognitive Behavioral Restructuring, Eye Movement Desensitization and Reprocessing (EMDR) for specific therapeutic interventions, as evidenced based practices and may recommend outside peer support utilizing 12-Step modalities.*
- Medical Model: *PST does not contract with any provider for psychiatric evaluations, yet may recommend and provide referrals if necessary for alternative mood stabilization. I agree and understand that I will inform PST staff of all medical history ~ and may need a history & physical to be conducted by a primary care physician to ensure biomedical wellness prior to conducting intensive therapy interventions; medications prescribed by providers need to be disclosed to PST staff. Additionally, PST may request the approval to share with your other providers intensive interventions utilized to ensure biomedical safety.*
- Risks: *I understand that I will be informed of the risks of not proceeding with the proposed treatment recommendations, as well as, PST staff may discontinue services if I don't comply with recommendations; I understand that I have been given information of any alternatives to the proposed treatment; I have been given a description of any clinical factors that might require suspension or termination of the proposed treatment; I understand that any consent given may be withheld or withdrawn in writing or verbally at any time and will be documented in the medical record.*
- Consent to Revoke: *I understand that if this consent is revoked, treatment must be discontinued, except in cases in which abrupt discontinuation of treatment may pose an immediate risk. In such cases, I understand that treatment may be phased out to avoid any harmful effects.*
- Transfer of Services: *I understand that at any time I can request a transfer of services to another provider if I chose without recourse and that any data collected during treatment is confidential and will not be disclosed without my permission except as allowed by law.*
- IN CASE OF EMERGENCY: I understand that if I need to speak with a clinician after hours due to a NON~LIFE THREATENING emergency, I can reach an on-call clinician through the answering service at: **602-703-3457**. If I or someone else is in immediate and serious physical danger, I agree to call **911** or **602-222-9444** for crisis response. Suicide Crisis Line: **1-800-273-8255**

By signing below, I acknowledge that I have been allowed the opportunity to ask questions and to have any questions answered in a satisfactory manner.

____ ____________

Patient Signature DATE

Update: 06-19-2021

PARADIGM SHIFT THERAPIES, LLC

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of alcohol and drug abuse patient records maintained by this provider is protected by Federal Law and Regulations (42 & 45 CFR Part II). Generally, the provider may not say to a person outside the program that a patient attends treatment for alcohol or drug use, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. *The patient consents in writing; or*
2. *Clinic staff or personnel are subpoenaed AND court ordered to release patient information; or*
3. *There is a medical emergency and staff must inform medical personnel of vital information; or*
4. *The clinic must release minimal information (i.e. age, race, sex, etc.) to qualified personnel for purposes of state audits or board of behavioral health evaluations.*

Violation of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Federal Law and Regulations do not protect any information about a crime committed by a patient either at the program or against program property or personnel. This includes any threat to commit such a crime.

Federal Law and Regulations do not protect any of the following information if reported by any patients:

- *Any information about suspected child abuse or neglect;*
- *Any information about suspected elder abuse or neglect;*
- *Any information leading staff to believe patient is in danger of harming self or others, which may be considered suicidal or homicidal ideation.*

State Law and Regulations:

- Patient records will be retained by Paradigm Shift Therapies, LLC for 6 years following the termination of treatment; After which, records will be destroyed unless there have been further transactions, therapy or claims between the patient and the therapist.

This above information must be reported under the mandatory reporting laws in this state, to the appropriate officials immediately.

PATIENT SIGNATURE: ___________________________________ DATE: _____________

PARADIGM SHIFT THERAPIES, LLC

Consent for Drug and/or Alcohol Treatment
(if applicable, please complete)

_____I hereby authorize and give voluntary consent to Paradigm Shift Therapies, LLC staff to provide treatment for my substance use.

_____ The procedures to treat my condition have been explained to me in the above Consent for Treatment, and I understand that I will be expected to participate in my recovery and treatment.

_____ I understand that I will be provided a copy of my treatment plan(s) detailing the course of action I have participated in developing and agreed to follow to meet my treatment goal(s).

_____ I agree to keep all scheduled individual and or group sessions or to give the staff a minimum of 24 hours' notice to cancel the appointment and or to re-schedule if possible.

_____ I understand that if I do not give appropriate notice, I will be charged to my credit card on file, a $25.00 fee.

_____ I understand that relapse may occur during recovery. The staff at Paradigm Shift Therapies, LLC is trained to assist me in discovering the events that led to relapse and possible solutions. I agree to abstain from using any illegal mood altering substance, alcohol and even medically prescribed marijuana within 24 hours prior to the therapy session.

Patient Signature: _____________________________________ Date: _________________

I REVOKE this authorization on: _____________ _____________________________

DATE SIGNATURE OF PATIENT

Notice of Privacy Practices

This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by two federal laws; the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 42 U.S.C. 1320det seq,, 45 C.F.R. Part 160 & 164 and the Confidentiality Law, 42 U.S.C. 290dd-2, 42 C.F.R. Part 2. Under these laws, Paradigm Shift Therapies, LLC may not say to a person outside Paradigm Shift Therapies, LLC that you attend the program, nor may Paradigm Shift Therapies, LLC disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

Paradigm Shift Therapies, LLC must obtain your written consent before it can disclose information about you for payment purposes. For example, Paradigm Shift Therapies, LLC must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Paradigm Shift Therapies, LLC can share information for treatment purposes or for health care operations. However, federal law permits Paradigm Shift Therapies, LLC to disclose information without your written permission:

1. Pursuant to an agreement with a qualified service organization/ business associate
2. For research, audit or evaluations.
3. To report a crime committed on Paradigm Shift Therapies, LLC premises or against Paradigm Shift Therapies, LLC personnel.
4. To medical personnel in a medical emergency.
5. To appropriate authorities to report suspected child abuse or neglect.
6. As allowed by a court order.

For example, Paradigm Shift Therapies, LLC can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified services organization/ business associate agreement in place.

Before Paradigm Shift Therapies, LLC can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Your Rights:

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. Paradigm Shift Therapies, LLC is not required to agree to any restrictions you request, but if it does agree, then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. Paradigm Shift Therapies, LLC will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Paradigm Shift Therapies, LLC, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in Paradigm Shift Therapies, LLC records, and to request and receive an accounting of disclosures of your health related information made by Paradigm Shift Therapies, LLC during the six years prior to your request. You also have the right to receive a paper copy of this notice.

Paradigm Shift Therapies, LLC Duties:

Paradigm Shift Therapies, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Paradigm Shift Therapies, LLC is required by law to abide by the terms of this notice. Paradigm Shift Therapies, LLC reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact our Compliance Officer

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or n response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to us using the contact information listed at the end of this Notice. You also may submit a written compliant to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer. The contact information is provided below.

Contact Officer: Todd Scherzer, MA, LPC, LISAC
Address: 389 E Palm Lane, Phoenix, AZ 85004
Phone #: 602-703-3457

I have read, understood, and received a copy of the Paradigm Shift Therapies, LLC Notice of Privacy Practices and a copy of this form will be retained in my medical chart.

PATIENT SIGNATURE: ____________________________________ DATE: ________________

PARADIGM SHIFT THERAPIES, LLC

Patient Resources

Consumer Reporting Resources	Consumer Community Resources
Az Department of Health Services 150 N. 18th Avenue, 4th Floor Phoenix, AZ 85007 602-364-2595	Crisis Line: 800-631-1314 / for TTY: 800-327-9254 Banner Health Crisis: 602-254-HELP (4357) Crisis Line: 602-222-9444
Adult Protection Services (APS) 1122 N. 7th Street, Suite # 205 Phoenix, AZ 85006 602-255-0996 or 1-877-767-2385	Urgent Psychiatric Care (UPC) 903 N. 2nd Street Phoenix, AZ 85004 602-416-7600
Department of Economic Security (DES) 1717 E. Jefferson Phoenix, AZ 85007 602-542-4791 or 602-542-5339	Community Bridges (for detox and crisis) 1-877-931-9142
Department of Child Services (DCS) 1789 W. Jefferson Phoenix, AZ 85007 1-888-767-2445 or 1-888-SOS-CHILD	Contacs (Maricopa County Shelter Hotline) 602-263-8900 or 1-800-799-7739
Department of Behavioral Health Services 150 N. 18th Avenue, 2nd Floor Phoenix, AZ 85007 602-364-4558	HIV Case Management Care Directions 1366 E. Thomas, Suite #200 Phoenix, AZ 85014 602-264-2273
Human Rights Advocacy 150 N. 18th Avenue, 2nd Floor Phoenix, AZ 85007 602-364-4558	HIV Services Southwest Center for HIV/AIDS 1101 N. Central Avenue, Suite #200 Phoenix, AZ. 85004 602-307-5330
Maricopa County Behavioral Health Services 1-800-564-5465	HIV Medical Services McDowell Clinic Phoenix, AZ 85006 602-344-6559
	Emergency Food Assistance St. Mary's Food Bank 3003 W. Thomas Phoenix, AZ 85009 602-415-5474

By Signing Below, you are acknowledging receipt of the Consumer Reporting Resources for Arizona and Emergency Resource Agencies available in Maricopa County:

____ ____________________

Patient Signature Date

PARADIGM SHIFT THERAPIES, LLC

Patient Rights

Your rights are provided as follows:

1. You have the right to fair and impartial treatment regardless of race, sex, sexual orientation, age, source of payment, etc., and for the program to convey a sense of trust and dignity.
2. You have the right to have your clinical records forwarded to another provider if you choose.
3. You have the right to be informed of all program services which may be of benefit to your treatment.
4. You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.
5. You have the right to express your preferences regarding choice of therapist therapeutic interventions.
6. You have the right to be informed of your diagnosis, treatment plan, and prognosis.
7. You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimate of the costs of treatment, proposed interventions, treatment, services, and a description of the alternatives to treatment.
8. You have the right to be informed if the facility proposes to perform experiments that affect your own treatment, and the right to refuse to participate in such experiments.
9. You have the right to examine your bill for treatment and to receive an explanation of the bill.
10. You have the right to be informed of the program's rules for your conduct at the facility.
11. You have the right to refuse treatment to the extent permitted by law and to be informed of the consequences of such refusal.
12. You have the right to receive respectful and considerate care.
13. You have the right to receive continuous care and to be informed of your appointments.
14. You have the right to have any reasonable request for services satisfied by the program, considering the ability to do so.
15. You have the right to safe, healthful, and comfortable accommodations.
16. You have the right to confidential treatment. This means that, other than exceptions defined by law (such as those in which public safety takes priority) without your explicit consent to do so in the program may release no information about you, including confirmation or denial that you are a patient.
17. Waiver of any civil rights or other right protected by law cannot be required as a condition of program services.
18. You have the right to freedom from emotional, physical, psychological, intellectual, fiduciary, or secular harassment or abuse.
19. You have the right to access and view your clinical file under the supervision of staff.
20. You have the right to privacy.
21. You have the right to access pertinent information in sufficient time to facilitate decision making.
22. You have the right to access or referral to legal entities for appropriate representation.
23. You have the right to access self-help and advocacy support services.
24. You have the right to ethical guidelines when you are involved in any research project. This includes informed consent before initiating any project.
25. You have the right to crisis intervention, when in need, that does not utilize seclusion or restraint procedures.
26. You have the right to receive written procedures governing the use of special treatment interventions and restrictions of rights.
27. You have the right to methods that ensure that intrusive procedures are administered in a safe manner, with consideration given to your physical, developmental and abuse history.
28. You have the right to file a complaint with the state if the facility's appeal procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint.

Patient Signature:____ Date: _____________

ELECTRONIC COMMUNICATION AUTHORIZATION

PARADIGM SHIFT THERAPIES, LLC
AUTHORIZATION FOR RELEASE OF INFORMATION
THE USE OF ELECTRONIC COMMUNICATION UTILIZING SECURE ENCRYPTED SERVER

389 E Palm Lane
Phoenix, AZ 85006
(602) 703-3457
Secure Email: todd@paradigmshifttherapies.com

The behavioral health information collected and provided by Paradigm Shift Therapies, LLC through its electronic means or a voice message to the client, health care professionals, schools, caregivers and or guardian, is provided only at the consent of the client and or guardian or health care power of attorney.

There could be possibilities that protected health information (PHI) is contained in such emails and potentially may be disclosed to, intercepted by, an unauthorized third party(s). We at Paradigm Shift Therapies, LLC will not disclose:

- Highly sensitive or personal information via communication through email or voice message unless consented below; or
- When using email or leaving a voice message, the information transmitted will be minimum information.
- PLEASE do NOT email or text confidential information without using a VPN provider as PST LLC cannot guarantee the safe and secure transmission;
- PST LLC does utilize a VPN service to keep transmitted information encrypted and confidential.

By signing below, you authorize Paradigm Shift Therapies, LLC to communicate minimal certain PHI via voice message, fax, or email **to me** at the following phone #: ___________________________________ or

email: ____, or to a third party for coordination of care.

I understand that I have the right to **revoke** this authorization at any time but must do so in writing. I understand that the **revocation** will not apply to information that has already been released in response to this authorization.

This authorization is valid through the dates below:

Today's Date _________ (Initial Here) **Expiration Date** __________ (Initial Here) OR **30 Days after Discharge**_______ (Initial Here)

Should information under this consent be disclosed to others by the recipient, it is no longer considered PHI covered under this consent.

_________________________________ ____________
Client or Parent/ Guardian Signature **Date/Time (Required)**
(If Patient is under the age of 18, I certify that I am authorized to seek medical treatment on behalf of this child.)

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.

I revoke this authorization on: ___________________________________; ____.
(Date Revoked) Signature

PARADIGM SHIFT THERAPIES, LLC

Fee Schedule:

Outpatient Counseling Fees:

- General Mental Health Counseling and Drug & Alcohol Counseling are available for as long as deemed necessary by both participants, you the patient and the primary counselor.
- Treatment Fees are non-refundable. If you need to miss a scheduled appointment, you need to call and cancel the appointment **24 hours in advance** or you may/will be charged a $60.00 fee (Effective 08/01/2021).
- Additional service fees outside of the scope of counseling will be determined based on the services requested, i.e. specialty services for trauma, DUI Assessment Screening/Revocations, or FMLA documents, etc.
- Fees must be kept current for any additional services to be rendered.
- Paradigm Shift Therapies, LLC staff has the right to change the treatment fees at any time. However, we will give you a 30 days' notice prior to any changes.

Fees Accepted by Cash, Credit Card or Money Order for the following services:

- Prescreening Assessment: $ 0.00
- Comprehensive Assessment: $150.00
- Individual Counseling: $120.00 / hour
- Group Counseling: (not available at this time) $ 00.00 / hr grp
- Family Counseling: $160.00 / hour
- Telephone Intervention $80.00 / hour
- FMLA / Disability Documentation (Original paperwork): $20.00 / 15 minutes
- Follow-up (maintenance monthly paperwork): $10.00 / 15 minutes
- BioMedical Consultation: $20.00 / 15 minutes
- Case Management Services: $60.00 / hour
- Sliding Fee Scales may apply based on treatment history: $__________________
- Subpoena for any court case: $400.00 / hour

Insurance Applicable Coverage and Your Responsibility:

- If you, the patient, has insurance coverage through the healthcare market place, you automatically qualify for behavioral health services, yet may submit your own insurance claim to your insurance provider for benefits and application towards your deductible. PST does not submit billing to "non-contractual" insurance providers on your behalf.

____ _______________
Patient Signature Date

____ _______________
Guarantor (if required) Date
Address if different than client:

Update: 06-19-2021

PARADIGM SHIFT THERAPIES, LLC

FINANCIAL AGREEMENT &
Fee Payment, Changes, & Refund Notice

Fee Payment
I understand that Paradigm Shift Therapies, LLC (PST) receives fees for services at the time those services are provided, unless I have made other arrangements that have been entered into this fee agreement. I understand that I am applying for admission to services provided by PST and must abide by this Financial Agreement for PST to continue to provide services to me.

Fee Disclosure & Changes
I understand that PST's fees have been disclosed to me, and a copy of the fee schedule has been provided to me. I also understand that I will be given at least a thirty (30) day notice of any scheduled fee changes for services I may be receiving at PSG.

Fee Refunds
In the event that I choose to self-terminate treatment or my services are terminated by PST due to a rule and/or violation, all payments made in advance for undelivered services will remain the property of PST. I understand that consumer fee refunds for undelivered services require that the patient complete a written request for the approval of the director of PST. All refunds will be made by PST in check within 10 working days. PSG does not give cash refunds.

Financial Agreement
I agree to pay the following fees based upon my eligibility for services: (check one)

_____ **Complete Fee** as listed in the PST Fee schedule for services; basic fee is for a 55 minute session ~ Longer, shorter, and Telephone sessions are prorated from the basic fee.

_____ **Partial Fee** as determined by eligibility for PST services; all non-allowable co-pays & deductibles are due at service.
INITIAL I am using the following Payer for my services:____ and based upon the fee schedule calculation provided by that Payer, I will pay _________$ or % of the Complete Fee for any given service I receive. I understand that on my behalf, PST will submit billing of service encounters to my Third Party Payer for reimbursement.

_____ I further understand that I must agree to inform PST of any change of income that may my ability to pay. I understand and agree
INITIAL that my fee may be changed as a result of a change in my income.

_____ I understand that I can request a SuperBill to be generated for me to file on my own with my insurance provider if provider is not contracted with your insurance plan.

Payment Agreement:
I authorize PST to keep my signature on file and to charge my account for the following:

_______ All "client portion" balances not paid by after 30 days, total not exceeding 3 sessions, or $300.00;
INITIAL

Credit Card / HSA / FSA Information:
Cardholder
Name:________________________________ DOB: _____________ Signature: ___________________________

Card #: ________________________________ Exp. Date: _________ Security Code: (3 or 4 digits code): ________

Address: ______________________________ City: _____________ Zip: ________________________________

I hereby acknowledge that I have read and understand the foregoing and that I voluntarily accept all the conditions contained therein.

_______________________________________ _______________
Patient Signature Date

_______________________________________ _______________
Guarantor (if required) Date

COVID-19 Pandemic Informed Consent

I, ______________________________, knowingly and willingly consent to attend face-to-face counseling during the COVID-19 pandemic. (PLEASE PRINT YOUR NAME HERE)

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. It is impossible to determine who has it and who does not given the current limits in people testing. _______ INITIAL HERE

I understand travel significantly increases the risk of contracting and transmitting the COVID-19 virus and the CDC recommends social distancing of at least 6 feet for a period of 14 days after traveling. I confirm that I have not traveled inside/outside of the United States of America, via: aircraft, train, bus, cruise ship, etc. to locations that might have contributed to infection risks. _______ INITIAL HERE

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below: _______ INITIAL HERE

Fever; Shortness of breath; Consistent dry cough; Runny nose; Sore throat

I understand that during this health emergency, Paradigm Shift Therapies, LLC (PST) understands the importance of informing our clients of the steps we are taking to ensure procedures are implemented to minimize the risks for COVID-19 transmission. Key areas of focus include, but are not limited to, the following: _______ INITIAL HERE

- Telehealth Video Conferencing Services: Doxy.me is the HIPAA compliant service used at PST; unfortunately the commercial insurance plans have not disclosed date of coverage discontinuance. Therefore, PST highly encourages each client to inquire with their insurance company for coverage benefits as PST cannot guarantee coverage.
- Confidentiality and HIPAA Compliance: PST will continue to maintain the confidentiality of all records of Protected Health Information; Arizona Department of Health Services may require officials tracking the COVID-19 limited information if exposure was identified at this facility. Please see Notice of Privacy Practices for detailed information.
- Scheduling Sessions: PST will be open normal business hours; Since the virus may potentially be in the air and on the furniture, staff will do their best not scheduling back-to-back sessions to allow any potential particles in the air settle down; Staff will routinely clean and disinfect the office space and furniture; Staff will also be checking clients for any indication of fever using an infrared thermometer. If fever is present, we will reschedule the appt. for a later date.
- Clients: PST requests clients to be knowledgeable of CDC and Arizona Department of Health recommendations regarding coughing/sneezing etiquette and handwashing hygiene, as well as the use of facial mask; In addition, it is highly discouraged for physical contact such as, shaking hands, and to maintain social distancing of 6 feet; if the practitioner is providing EMDR services, PPE may/will be utilized based on circumstance. If by chance you are experiencing any of the above COVID-19 symptoms listed above, we request that you reschedule your appointment after symptoms dissipate and seek medical services for clearance. If you have a job that exposes you to other people who are infected, or you have family members who are infected, please inform our staff immediately.
- Staff: If a staff member experiences signs/symptoms listed above, the staff will cancel sessions and if testing positive for COVID-19, the office will shut down operations until medically cleared. Staff will use personal protective equipment for safety as deemed necessary.
- Therapy Service Animal: CDC key points regarding the risk animals play in spreading the virus suggests there is no evidence animals spread COVID-19 to people, noting the risk is low. Therefore, use precautions when greeting the Therapy Dog; if you prefer no contact, please indicate so to the clinician.

If you have any questions, please don't hesitate to ask. When you sign this document, it will be an official agreement between us.

______________________________ CLIENT SIGNATURE   __________ DATE

______________________________ STAFF SIGNATURE   __________ DATE

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often or very often**…
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**…
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
Yes No If yes enter 1 ________

4. Did you **often or very often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 ________

5. Did you **often or very often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk/high to take care of you or take you to the doctor?
Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 ________

7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
Yes No If yes enter 1 ________

10. Did a household member go to prison?
Yes No If yes enter 1 _______

Now add up your "Yes" answers: _______ This is your ACE Score.

Brief Adult Outcome Questionnaire

Date: _____ **Client:** _____

Clinician: _____ **Treatment Site:** _____

This Brief Questionnaire asks about some of the most commonly reported thoughts, feelings and behaviors among adults seeking behavioral health treatment. Please think about the past two weeks and answer the questions below to the best of your ability. This will help you and your therapist plan your treatment and monitor your improvement.

How often did you…	**Never 0**	**Hardly Ever 1**	**Some-times 2**	**Often 3**	**Very Often 4**
Feel unhappy or sad?					
Have little or no energy?					
Have a hard time getting along with family, friends or coworkers?					
Feel hopeless about the future?					
Have a hard time paying attention?					
Feel unproductive at work or other daily activities?					
Feel tense or nervous?					
Have problems with sleep? (too much or too little)					
Feel lonely?					
Do you worry what others will not like about who you are on the inside?					
Do you have trouble trusting others?					
Do you have a physical reaction when you are reminded of an upsetting experience? (ex: heart beating fast)					
Think about harming yourself?					
Have some express concerns about your alcohol or drug use?					
Have more than five drinks of alcohol at one time?					
Do you have upsetting thoughts or images when reminded of a past experience?					
Have a problem at work, school, or home because of alcohol or drug use?					

Total Points: ________ / 17 = _______

DSM – 5: SELF-RATED LEVEL 1 CROSS-CUTTING SYMPTOM MEASURE – ADULT

Client Name: ____			Date: _____________________			CLINICIAN USE
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Slight Rare, less than a day or two	Mild Several Days	Moderate More than half the days	Severe Nearly every day	HIGHEST DOMAIN SCORE
1. Little interest or pleasure doing things?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	
2. Feeling down, depressed, hopeless?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	______
3. Feeling more irritated grouchy, angry than usual?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	______
4. Sleeping less than usual, but still have a lot energy?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	______
5. Starting lots more projects than usual or doing more risky things than usual?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	______
6. Feeling nervous, anxious, frightened, worried, or on edge?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	
7. Feeling panic or being frightened?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	______
8. Avoiding situations that make your nervous?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	
9. Unexplained aches and pains (e.g., head, back, joint)?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	
10. Feeling that your illnesses are not being taken seriously enough?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
11. Thoughts of actually hurting yourself?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	
12. Hearing things other people couldn't hear, such as voices even when no one was around?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	
13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
14. Problems with sleep that affected your sleep quality overall?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
17. Feeling driven to perform certain behaviors or mental acts over and over again?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
19. Not knowing who you really are or what you want out of life?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
20. Not feeling close to other people or enjoying your relationships with them?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
21. Drink at least 4 drinks of any kind of alcohol in a single day?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
22. Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____
23. Use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue) or methamphetamine (like speed)]?	_____ 0	_____ 1	_____ 2	_____ 3	_____ 4	_____

NIDA-Modified ASSIST

Cross-cutting Questionnaire:

In your LIFETIME, which of the following substances have you ever used?	YES	Not at all	1-2 days / week	Several Days / week	More than half	Nearly Every day	Daily	Age of 1st use	Last date used?
Alcohol:	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Cannabis (marijuana, pot, grass, hash, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Cocaine (coke, crack, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Prescription stimulants (Ritalin, Dexedrine, Adderall, diet pills, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Methamphetamine (speed, crystal meth, ice, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Sedatives or sleeping pills (Valium, Ativan, Xanax, Rohypnol, GHB, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Street opioids (heroin, opium, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Hallucinogens (LSD, acid, PCP, mushrooms, Special K, ecstasy, etc.)	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Other – specify: Spice /	_____	____**0**	____**1**	____**2**	____**3**	____**4**	____**6**	_____	_____
Has any of these been IV use?	Y___	N___							