Print Packet and Bring Forms to Initial Consultation

INSTITUTE FOR EMOTIONAL HEALING

las palomas bldg ■ 4256 n. brown ■ suite b ■ scottsdale, az 85251

Personal Data Summary

Name_____ Birth Date_____

Address_____ Age_____ Sex_____

_____ Cell Phone_____

City State Zip

Home Phone_____ E-Mail _____

Marital Status_____ Education (Last Degree)_____

Employment Information

Employer_____ Title_____

Address _____ Start Date _____

_____

City State Zip

In Case of Emergency, Contact

Name_____ Relationship_____

Address_____ Phone_____

_____

City State Zip

How did you hear about us?

Internet Search _____ Website _____ Referred by _____

Insurance Information

Name of Company _____ Phone _____
Address_____ Group #_____
_____ Insured's DOB _____
City State Zip Insured's ID # _____
Name of Insured_____ Relationship to Client _____

Patients or authorized person's Signature
I authorize the release of any medical information necessary to process this claim. I also request payment of Government Benefits either to myself or to the party who accepts assignment below.

Signed _____ Date _____

I Authorize payment of Medical Benefits to undersigned Physician or supplier for service.

Signed insured or authorized person _____

For Office Use Only

Visual ID Check ☐ Visual Insurance Card Check ☐
Initial Consult Date_____ Comments _____
Therapist_____ _____
DX Code_____ _____
Fee or Co-pay_____ _____

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AUTHORIZATION FOR TEXT/EMAIL COMMUNICATION

I, _____authorize the use of text and email technology for the purposes of appointment scheduling and confirmation, and for the transmission of non-protected information between myself and Institute for Emotional Healing.

I understand that timely cancellation of scheduled appointments as well as any communication of an urgent nature must still be done through phone call/voicemail.

I understand that no encryption technology is used and therefore no protected healthcare information should be shared through text or email as privacy cannot be guaranteed.

_____ _____

Signature Date

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PSYCHOTHERAPY NOTES STATEMENT

I understand that during the course of therapy, my therapist will make notations referred to as 'psychotherapy notes'. These notations are for the sole use of my therapist and may contain impressions, reminders and thoughts, as well as sensitive personal information about myself or others. THESE NOTES ARE FOR MY THERAPIST'S EYES ONLY. These notations will be clearly labeled 'psych' or 'psychotherapy notes' and while physically existing in my file, will not be considered part of my official medical record. Consequently, any such notes will not be released in any request for medical records by myself or any third party.

_____
Name of Client

_____ _____
Signature of Client Date

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TREATMENT PLAN & INFORMED CONSENT

Client Name: _____

Please check your treatment goals below. Check all that apply.

Year		
20	20	20
☐	☐	☐	Decrease/eliminate depression ..... Are you suicidal? ☐ Yes ☐ No
☐	☐	☐	Decrease/eliminate anxiety or panic attacks
☐	☐	☐	Reduce/eliminate feelings of hopelessness
☐	☐	☐	Improve body image
☐	☐	☐	Learn decision-making and problem-solving skills
☐	☐	☐	Learn to negotiate and compromise
☐	☐	☐	Learn to express anger appropriately ....Violence towards others? ☐ Yes ☐ No
☐	☐	☐	Learn assertiveness or other communication skills
☐	☐	☐	Reduce aggression
☐	☐	☐	Reduce passivity
☐	☐	☐	Improve communication skills
☐	☐	☐	Reduce/eliminate self-injury
☐	☐	☐	Decrease/eliminate mood swings
☐	☐	☐	Increase ability to handle frustration or irritability
☐	☐	☐	Reduce anger and irritability
☐	☐	☐	Reduce fears of being alone or being abandoned
☐	☐	☐	Decide about divorce/separation
☐	☐	☐	Deal with impact of divorce/separation/relationship termination
☐	☐	☐	Heal from abusive childhood
☐	☐	☐	Recover from abusive relationship
☐	☐	☐	Heal from a loss/grief issue
☐	☐	☐	Learn to identify, tolerate, and express feelings
☐	☐	☐	Reduce/eliminate guilt or shame
☐	☐	☐	Reduce/eliminate obsessive thoughts and/or compulsive behavior
☐	☐	☐	Learn to make friends and/or develop a support network
☐	☐	☐	Reduce/eliminate feeling disconnected or socially isolated
☐	☐	☐	Learn to slow down racing thoughts
☐	☐	☐	Decrease/eliminate dependency or co-dependency
☐	☐	☐	Reduce sensitivity to criticism
☐	☐	☐	Learn to set boundaries
☐	☐	☐	Learn to set and accomplish goals
☐	☐	☐	Explore spirituality
☐	☐	☐	Increase focus, attention, and concentration
☐	☐	☐	Cope with pain or physical disability or illness
☐	☐	☐	Combat addictive behaviors in self
☐	☐	☐	Address addictive behaviors in a loved one
☐	☐	☐	Explore sexual expression/desire issues
☐	☐	☐	Explore sexual orientation
☐	☐	☐	Recover from sexual abuse

I understand the following issues related to Informed Consent:

Purpose of Treatment: To relieve emotional distress and to help people with mental illness change their attitudes and/or behavior.

Methods and Goals: This is an ongoing process between you and your therapist. Together we decide what you want to accomplish and how best, given your personality, preferences, and issues, to treat and relieve the symptoms you are experiencing. Generally this refers to supportive, behavioral, and cognitive methods of therapy. Also, a process can be chosen in which one changes their present situation through dealing with the past and in many, if not most cases, this is an intricate part of the treatment provided here. This is called psychodynamic treatment. Finally, we may consider how your "system" of family and friends supports change or inertia in your life and this can involve family systems therapy. Type, length, and treatment itself is molded as we go and your process develops.

Benefits of Treatment: To reduce suffering related to anxiety, panic, obsession, phobias, depression, post-traumatic stress disorder, personality disorders, bipolar, or other adjustment to life issues.

Limitations in Treatment: Therapy is a process and not every match between therapist and client is a good one. Also, treatment often improves situations but does not offer a panacea for life. You must participate fully or progress can be stalled or fail to move forward at all. And, in some cases, even with the best of treatment improvement is minimal. If you find you are not making the progress you would like to make then please discuss this with your therapist.

Potential Risks of Treatment: Treatment can be upsetting to you and those around you as you confront issues, begin to change, and grow. As in any form of "treatment" there are risks of a treatment working for one person and not another. Also, as therapy is an evolving process, you may uncover unexpected issues which bring pain and other feelings which you will then face working through. This is part of the therapeutic process but you may feel "worse" before you feel "better". Finally, friends and family are not always supportive of growth and the changes a person makes and this can result in new challenges within those relationships.

I understand that I am an active participant in my therapy and can freely disagree with my counselor at any time and can choose whether or not to act on suggestions made by my counselor. I agree that I have reviewed the following forms. I may, at any time request a copy of this and any of the following forms:

___ Policies & Procedures: Having read and understood them, I agree to abide by these policies and procedures.
(Click to review before **initialing** here and **signing** below)

___ Limits of Confidentiality:Having read and understood them, I agree to these limits of confidentiality.
(Click to review before **initialing** here and **signing** below)

_____		_____	
Signature of Client	Date	Therapist	Date
_____		_____	
Signature of Client	Date	Therapist	Date
_____		_____	
Signature of Client	Date	Therapist	Date

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Acknowledgement of Receipt of Privacy Notice

Review the HIPAA Notice of Privacy Practices before signing.

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Institute for Emotional Healing (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 4256 N. Brown Ave, Suite B, Scottsdale, AZ 85251, Attention: Christina DeVita, Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.
   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____ Other (explain) _____

Signature of Authorized Practice Representative _____ Date _____

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POLICIES AND PROCEDURES

1. **Sessions**: Sessions are most commonly scheduled in 45-50 minute increments. This is referred to as a 'session hour'. At times you may choose to schedule an extended session of 75-90 minutes. In order for your session time to be used beneficially, it is extremely important that you be prompt. This time is reserved for you and will not be extended to accommodate late starts.

2. **Telephone Procedures**: Your therapist has limited office hours when she may be available to answer the phone. Messages may be left for her at any time; however, if she is unable to return your call during her office hours, you will probably hear from her the next business day. If you have an urgent need for a return call the same day, please state this in your message. It may take several hours to return a call. If you have an emergency and cannot wait for a return call, call 911 or the Banner Crisis Line at 602 254-HELP or 602 254-4357.

3. **Fees and Payment**: Fees shall be discussed and set prior to or during your initial consultation with your therapist. You are fully responsible for all fees charged. Payment for each session is due in full at the time the service is provided unless other arrangements have been made prior to the session. If your therapy is covered by your health insurance, you will be responsible for any unmet deductible and/or copay at the time of services [see below for more]. Occasionally, payment schedules may be adjusted based on a change in a client's financial circumstances. Fees may be paid by cash, check, credit, debit or HSA. A $35.00 service fee shall be assessed for returned checks or denied credit.

4. **Insurance**: Every effort will be made to obtain accurate reimbursement information from your health insurance company prior to treatment. This office will bill your insurance company directly and will accept payment directly from them in most cases. Such billing is usually done quarterly and it can sometimes take as much as 60 days for a return response. In the unlikely event that our office is given inaccurate information and anticipated reimbursement is not forthcoming from your insurance company, you will be responsible for unpaid, eligible charges. In this event we will do our best to arrange a workable repayment schedule with you. During the course of treatment, if your insurance coverage changes or ends, notify us immediately so that we can determine an appropriate, new fee plan.

5. **Communication**: Unless you make other arrangements, we will contact you by phone, mail, email, or text at the addresses and phone numbers provided by you on your intake form. Discretion and confidentiality will be taken into account. Please let your therapist know of any special requirements you have in terms of any of these communication methods. Otherwise, acceptance of this form implies consent for us to communicate as noted.

6. **Cancellation Policy**: A 24 hour cancellation policy is standard practice for therapists. This differs from medical doctors who can see many people in an hour and, therefore, can afford to be more flexible. Your timely cancellation will allow another client to use the time. We appreciate your consideration of your therapist's as well as other client's schedules. No charge will be assessed if adequate notice of 24 hours is given.

   FAILURE TO CANCEL A SCHEDULED APPOINTMENT WITH 24 HOURS NOTICE WILL RESULT IN CHARGES AS FOLLOWS: A $100 CHARGE WILL APPLY TO THE FIRST LATE NOTICE/NO NOTICE ABSENCE IN ANY CALENDAR YEAR AND A CHARGE OF THE FULL SESSION FEE WILL APPLY TO ALL SUBSEQUENT LATE NOTICE/NO NOTICE ABSENCES. INSURANCE CLIENTS, PLEASE REMEMBER THAT YOUR INSURANCE WILL NOT BE BILLED NOR WILL THEY MAKE ANY PAYMENT FOR MISSED SESSIONS. THE STATED FEES WILL BE FULLY OUT-OF-POCKET.

7. **Confidentiality and HIPAA**: The Institute for Emotional Healing adheres to a strict code of confidentiality in accordance with federal HIPAA guidelines. Posted Privacy Practices documents as well as the accompanying Limits of Confidentiality page will explain in detail the limitations of your privacy rights. In addition, please discuss any concerns or questions regarding confidentiality with your therapist. It is our intent to help you feel comfortable discussing your issues with your therapist in an open and honest way.

8. **Supervision**: Your therapist periodically consults with a supervisor or peer professional on cases as recommended by the state of Arizona and its ethical guidelines for counselors. Occasionally, your case may be presented during these sessions. You have the right to contact these professionals at any time. Please ask your therapist for the name and phone number of such professionals should you wish to speak with them. Like your own therapist, these professionals must conform to the guidelines outlined in the 'Limits of Confidentiality'.

9. **Additional Charges**: Charges of $150 may apply when copies of files or written reports are requested.

10. **Electronic Recording of Sessions**: No audio or videotaping of sessions is permitted without prior authorization by therapist and client.

11. **Credentials**: Your mental health practitioner's credentials are available through discussion with them at any time. There are various licenses in the State of Arizona and they will be glad to describe the Board under which they are licensed.

We hope that your work with us is a positive and growth-oriented experience. We are dedicated to the optimum in client care and we welcome your suggestions. Thank you for allowing us to help you.

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LIMITS OF CONFIDENTIALITY

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.

2. The client threatens harm to another person(s), including murder, assault, or other physical harm.

3. The client is a minor (under 18) and reports child abuse, including but not limited to, physical beatings and sexual abuse.

4. The client reports abuse of the elderly.

5. The client reports abuse of any minor (under 18).

6. The client reports sexual exploitation by a therapist.

7. Court ordered or subpoena of records by a judge.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

HAVING READ AND UNDERSTOOD THE ABOVE, I AGREE TO THESE LIMITS OF CONFIDENTIALITY.

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