New Client Forms

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male/Female/Nonbinary/Other: \_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_Middle Initial: \_\_\_\_

Pronouns: \_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_

Zip Code: \_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Note:

As a courtesy we will bill your insurance carrier on your behalf; however, we are not liable to any expenses that are not covered by insurance, and we reserve the right to contact you for payment.

Client or Guardian Name Printed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Guardian:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent**

Welcome! We look forward to working with you. Starting counseling is a major decision and you may have many questions. The purpose of this document is to inform you about what you can expect from counseling and give you the opportunity to consent with the counseling process.

We will discuss this during our first session.

1. I agree to participate in therapy services with Gilbert Counselors.
2. I understand that participating in these services is voluntary and collaborative.
3. I agree to verbally advise my therapist when I decide to terminate services. I understand that, unless otherwise contacted, no contact for 30 days will result in file closure; my file may be reopened upon agreement by both parties.
4. I understand that I will be participating in therapy services to address issues and concerns that I share with my therapist. I understand that the focus of the services is on helping me reach my individual goals. I understand that there are no guarantees that the services will make me, or my partner/family members feel better or resolve my problems, issues, or concerns. Furthermore, although I understand that the counseling process can open levels of awareness that are painful (e.g., I could feel upset, anxious, angry, and/or uncomfortable).
5. I understand that my client record will be kept confidential, and that confidentiality includes all aspects of the topics discussed within the therapeutic setting. I also understand that, by law, there are limitation to confidentiality and cases when one or more of the following occur: intent to commit suicide; intent to commit homicide; any other act or intention to act in a way that may be a danger to self or others; information regarding child or elder abuse that mental health care providers are mandated by law to report; a court subpoena for records; information regarding unprofessional conduct by another behavioral health professional. In addition, I understand that my therapist is justified in informing an identifiable third-party of risk of contagious/fatal disease.
6. I understand that my therapist may consult or seek supervision from a colleague when it is required or deemed necessary to ensure quality care. I understand that my identity will be protected.
7. I understand that email, fax, and cell phone communications are **not** guaranteed confidential methods of communication. Therefore, I understand that if I choose to contact my therapist via one of these methods, it is by choice, and that therefore relinquish my rights of confidentiality.
8. I understand that I have a right to request a copy of my record in writing. I understand that I also have the right to sign a written authorization that will allow my therapist to give and/or receive information verbally and in writing with individuals or entities that I designate.
9. I understand that I have the right to participate in treatment decisions, including the development of my treatment plan. My therapist will work with me to determine the recommended services based on my situation; however, I have the right to refuse treatment and to withdraw my informed consent from my treatment providing a written request. I understand that if I submit this request, Gilbert Counselors’ will no longer be able to provide me with services.
10. I understand that my therapist and/or Gilbert Counselors, LLC has the right to terminate services with me, whether for therapeutic or personal reasons. I understand that should this occur, I will be provided with information on how to obtain alternative therapy services (i.e., referral to another therapist or practice/treatment provider).
11. I understand that the therapy relationship is exclusively therapeutic (e.g., it is inappropriate for a client and a counselor to spent time together socially, to bestow gifts, or to attend family or religious functions). I understand that the purpose of these boundaries is to ensure that my therapist and I are clear in our roles for treatment and that my confidentiality is maintained.

**Consent for Telehealth Consultation**

1. I understand that my health care provider wishes me to engage in a telehealth consultation.

2. My health care provider explained to me how the video conference technology that will be used to

affect such a consultation will not be the same as a direct client/health care provider visit since I will

not be in the same room as my provider.

3. I understand that a telehealth consultation has potential benefits including easier access to care and

the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access,

and technical difficulties. I understand that my heath care provider or I can discontinue the telehealth

consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions

regarding this procedure. My questions have been answered and the risks, benefits, and any practical

alternatives have been discussed with me in a language in which I understand.

I certify that I:

• Have read or had this form read and/or had this from explained to me.

• Fully understand its contents including the risks and benefits of the procedure(s).

• Have been given ample opportunity to ask questions and that any questions regarding telehealth have been answered to my satisfaction.

**HIPAA**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND

DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**Please review it *CAREFULLY.***

The privacy of your health information is important to me.

**MY LEGAL DUTY**

I am required by applicable federal and state law, as well as the ethics of the counseling profession, to maintain the privacy of your health information. I am also required to give you this Notice about my practices, my legal duties, and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2006 and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information that I created or received before I made the changes. Before I make significant change in my privacy practices, I will change this Notice and make the new Notice available upon request.

You may request a copy of my Notice at any time. For more information about my privacy practices, or for

additional copies of this Notice, please contact me using the information listed at the top of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

I use and disclose health information about you for ***treatment,******payment,*** and ***healthcare operations***. For example:

***TREATMENT:*** I may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

***PAYMENT:***I may use and disclose your health information to obtain payment for services I provide to you.

***HEALTHCARE OPERATIONS:*** I may use and disclose your health information in connection with my healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**YOUR AUTHORIZATION:** In addition to my use of your health information for *treatment, payment,* or *healthcare operations,* you may give me written authorization to use your health information or to disclose it to anyone for anypurpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affectany use or disclosure permitted by your authorization while it was in effect. Unless you give me a written authorization, I cannot use or disclose your health information for any reason except those described in this Notice.

**TO YOUR FAMILY AND FRIENDS:** I may disclose your health information to you, as described in the *Patient Rights* section of this NOTICE. I may disclose your health information to a family member, friend, or other personto the extent necessary to help with healthcare or with payment for your healthcare, but only if you agree that I maydo so.

**PERSONS INVOLVED IN CARE:** I may use or disclose health information to notify or assist in the notification of (including identifying or location) a family member, your personal representative, or another person responsible for your care, of your location, your general conditions, or death. If you are present, then prior to use or disclosure of your health information, I will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. I will also use my professional judgment and my experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up filled prescriptions, medical supplies, or other similar forms of health information.

**MARKETING HEALTH-RELATED SERVICES:** I will not use your health information for marketing communications.

**REQUIRED BY LAW:** I may use or disclose your health information when I am required to do so by law.

**ABUSE OR NEGLECT:** I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**NATIONAL SECURITY:** I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials’ health information required by lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

**APPOINTMENT REMINDERS:** I may use or disclose your health information to provide you with appointment reminders (such as phone or voice messages).

**PATIENT RIGHTS:**

**ACCESS:** You have the right to look at or obtain copies of your health information, with limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I cannot practicably do so. I will charge you a fee for expenses such as copy costs and copy/preparation time. You may also request access by sending me a letter to the address at the end of this Notice. If you request copies, I will charge you for my time (at my regular hourly rate of $150), copy costs, and postage if you want the copies mailed to you. If you request an alternate format or a summary/explanation of your health information, I will charge my regular hourly fee for providing your health information in that format.

[Note: In the event that your records are co-mingled (i.e., if you are a part of a Child Custody Evaluation, Family Court Case, family therapy, mediation, or marriage counseling), I need a signed consent by all parties involved in order to release records. Third party records in your file (i.e. doctors, other professionals, and references) have the right to confidentiality, and will not be released by this office unless ordered to do so by law. Please contact those professionals directly for records.]

**DISCLOSURE ACCOUNTING:** You have the right to receive a list of instances in which I or my business

associates disclosed your health information for purposes, other *than treatment, payment, healthcare operations* and certain other activities, for the last six years, but not before January 1, 2006. If you request this accounting more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests.

**RESTRICTIONS:** You have the right to request that I place additional restrictions on my use or disclosure of your health information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in an emergency).

**ALTERNATIVE COMMUNICATION:** You have the right to request that I communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**AMENDMENT:** You have the right to request that I amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) I may deny your request under certain circumstances.

**QUESTIONS AND COMPLAINTS**

If you want more information about my privacy practices or have questions or concerns, please contact me.

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

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

**Office Policy and Financial Responsibility Statement**

Please carefully read the following information regarding private pay rates, insurance, length of sessions, late arrivals, late cancellations, and emergency calls.

Private Pay Rates:

* Therapy with a Masters Level Clinical Intern: $70
* Therapy with a Licensed Associate Counselor: $105
* Therapy with a Licensed Professional Counselor: $135
* Therapy with either Julia Spain or Terri Roman: $175
* Initial intake session is 53-60 minutes long. Additional sessions are subject to the private pay rate and are 45-53 minutes long.
* By agreeing to the private pay rate, you are consenting to opt out of any insurance claim submission or reimbursement from insurance at this time and in the future. Once a session is paid at the private pay rate, Gilbert Counselors, LLC will not submit a claim to insurance.

Insurance:

* We do bill some insurance companies, depending on the counselor. Billing insurance does not guarantee payment for services. It is your responsibility to verify your insurance benefits and associated costs. Copays and/or out-of-pocket costs are due at the time of service.
* **You are responsible for any balance resulting from, but not limited to copays, coinsurance, deductible, unpaid claims, etc. The non-insurance rates will be assessed for any missed appointments.**
* You will be charged the private pay rate for missed appointments without a 24-hour notice. A pattern of canceled or missed sessions may be indicative of problems in commitment to therapy and will addressed in session. Missing or cancelling three sessions within a 90-day period may result in termination of services. If you are late to an appointment, the therapy session will still end at the scheduled time. A missed appointment fee is not eligible for reimbursement with a FSA, HSA, or HRA. This fee will be charged to another form of payment, such as a credit card.
* Other professional services (e.g., telephone or e-mail sessions, or coaching sessions lasting longer than 10 minutes, report writing, coordination with other professionals, preparation of records or treatment summaries) will be billed at the same rate in 15-minute increments. Legal services (e.g., court appearances) and associated travel times will be billed at the same rate in 15-minute increments. Gilbert Counselors, LLC reserves the right to change fees with 30 days verbal notice.
* Payment is due at the beginning of each session. Gilbert Counselors accepts HSA/HRA cards, cash, check, or credit card. Returned checks will be assessed a processing fee of $25.00.
* You are financially responsible for all charges incurred for treatment. I understand that I am held liable for any balance due on this account and that this balance will be due and payable on demand. I further understand that overdue accounts, with my name on them, may be submitted to a collection agency.
* The office line of Gilbert Counselors, LLC as well as the therapists*’* individual phone number is NOT an emergency number. In the event of a psychological emergency, please call the **Crisis Line at (602) 222-9444**. In the event of a medical emergency, call **911** or go to the closest emergency room. Otherwise, you may leave a message and the , or your therapist, will get back to you as soon as possible or within 24-48 hours.

**Notification of Supervision: Clinical Interns and Licensed Associate Counselors**

This notification is being provided to you for transparency and coordination of care. I am a Master’s level therapist, and I provide therapy under clinical supervision. Please note that as a therapist I discuss my cases with my supervisor who provides clinical oversight over the services I provide within the practice. My supervisor is a Licensed Professional Counselor who is approved by the Arizona Board of Behavioral Health Examiners to provide clinical supervision to providers that are clinical interns or licensed at the associate level. If you would like to contact my supervisor directly to discuss treatment or address concerns, you may request their contact information.

Your active participation in treatment decisions is crucial to meeting identified goals. All services are voluntary (unless otherwise specified), and you have the right to end services at any time. There could be times when we might advise against ending services, as it could lead to greater risks. However, you are entitled to decline services at any time and at your own discretion.

**Acknowledgement of Intake Forms**

I acknowledge that I have read and agree with the following documents:

* HIPAA
* Informed In-person Consent
* Informed Telehealth Consent
* Office Policy and Financial Responsibility Statement

By signing this agreement, I am acknowledging that I have read, understand, and agree to adhere to Gilbert Counselors’ Clinical Policies and Procedures regarding Registration Policy and Procedure, No Show/Cancellation Policy and Procedure, Billing Policy and Procedure, HIPAA and Consents regarding Treatment, Telehealth, and Group Therapy (if applicable).

Client or Guardian Name(s) Printed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Guardian:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_