Desert Therapies and Wellness

7739 E. Broadway Blvd, St 324 Tucson, AZ 85710
520-979-5926

CONFIDENTIAL CLIENT INFORMATION—ADULT

Client Name: _____ Date of Birth: _____ M / F

Relationship Status (circle): Single Engaged Married Divorced Separated Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alternate Phone: _____

E-Mail: _____

Employment (circle): Full-time Part-time Not employed Student

Occupation_____ Employer/School_____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Family Physician or Primary Care Provider: _____

How were you referred to us? _____

General Information

Have you ever sought help in counseling before? Yes No

If yes, please explain: _____

Have you ever been hospitalized for a mental health reason? Yes No

If yes, please explain: _____

Have you ever had suicidal thoughts, feelings, or attempts? Yes No

If yes, please explain: _____

Have you ever been arrested? Yes No

If yes, please explain: _____

Do you currently have any homicidal or assaultive thoughts or feelings? Yes No

If yes, please explain: _____

Do you struggle with any of the following? (circle all that apply)

Anxiety Depression Sleep Issues Chronic Pain Anger Relationship Issues Trauma

Substances Co-Dependency ADD/ADHD Self Esteem Issues OCD Grief/Loss

Client Name: _____

Family History

Who raised you? _____

If there were changes, please list and indicate the sage you were when changes occurred:

_____

_____

# of siblings _____ # brothers _____ # sisters _____ Your place is the birth order _____

Which family members are you close to? _____

Which family members are a problem for you? _____

Who else provides emotional support for you? _____

Medical Information

Please rate your overall health: Very Poor 1 2 3 4 5 6 7 8 9 10 Very Good

Current medications: _____

Please list any significant medical conditions (HBP, Gastric Reflux, Fibromyalgia, etc.):

_____

Substance Use Information

What is your current substance usage (alcohol, caffeine, tobacco, cannabis, etc.):_____

_____

Do you recognize any addictions in your life (alcohol, drugs, gambling, sex, internet, work)? Yes No

If yes, please explain: _____

Religious/Spiritual History

Are religious and spiritual recourses important to you? Yes No

Are you open to sharing this part of your life as appropriate in your treatment? Yes No

Are you active in any local church or community of faith? Yes No

Congregation: _____ How often? _____

Do you have a favorite Bible story, verse or character? Yes No

If yes, please explain: _____

How do you maintain or nurture your spiritual life? _____

Client Name: _____

Briefly describe the problem for which you are seeking help:

_____

_____

SEVERITY OF PROBLEM: **0=NO PROBLEM 5=DISABLING**	**INDICATE ANY PROBLEMS IN THE** **FOLLOWING AREAS:**	**EXPLAIN**
0 1 2 3 4 5	Sleep too much	
0 1 2 3 4 5	Sleep too little	
0 1 2 3 4 5	Interrupted sleep	
0 1 2 3 4 5	Other sleep problems	
0 1 2 3 4 5	Memory	
0 1 2 3 4 5	Concentration	
0 1 2 3 4 5	Attention	
0 1 2 3 4 5	Loss of interest in usual activities	
0 1 2 3 4 5	Feelings of sadness	
0 1 2 3 4 5	Loss of energy	
0 1 2 3 4 5	Feeling tired all the time	
0 1 2 3 4 5	Periods of crying	
0 1 2 3 4 5	Feeling of hopelessness	
0 1 2 3 4 5	Loss of sexual desire	
0 1 2 3 4 5	Outbursts of anger	
0 1 2 3 4 5	Change in appetite	
0 1 2 3 4 5	Hearing voices when no person is present	
0 1 2 3 4 5	Unable to recall periods of time in childhood after age 5	
0 1 2 3 4 5	Unable to recall some period of your day	
0 1 2 3 4 5	Walking in sleep	
0 1 2 3 4 5	Nightmares	
0 1 2 3 4 5	Overwhelming fears	
0 1 2 3 4 5	Racing thoughts	
0 1 2 3 4 5	Thoughts that won't go away that are constantly in your head	
0 1 2 3 4 5	Thoughts of harming someone else	
0 1 2 3 4 5	Thoughts that some person or people are trying to harm you	
0 1 2 3 4 5	Noticing items in your home and not knowing where they came from or how they got there	

0 1 2 3 4 5	Feelings of being controlled by forces outside yourself
0 1 2 3 4 5	Feeling compelled to repeat activities for no reason
0 1 2 3 4 5	Unable to relax
0 1 2 3 4 5	Blackouts
0 1 2 3 4 5	Excessive sweating
0 1 2 3 4 5	Death of family members or friends
0 1 2 3 4 5	Panic attacks
0 1 2 3 4 5	Mood swings
0 1 2 3 4 5	Spending sprees
0 1 2 3 4 5	Changes in energy level
0 1 2 3 4 5	Other:

Any additional information you would like me to know.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Desert Therapies and Wellness

FINANCIAL AGREEMENT
And
GOOD FAITH ESTIMATE

COUNSELING FEES (individual, couple, family and EMDR) are $100 per 50-minute session. Payment is expected at the time of service unless other arrangements have been made. I accept ESA payments, and I can provide a super bill for reimbursement.

ACCEPTED METHODS OF PAYMENT: cash, credit, debit, HSA card or personal check. Checks are to be made payable to **Desert Therapies and Wellness.** There is a $40 fee for all returned check funds.

HEALTH INSURANCE: We will not bill your insurance directly. If you would like to use health insurance benefits for counseling, we ask that you pay your fee upfront, then seek reimbursement through your health insurance plan. Your counselor will provide you with the necessary forms for you to seek reimbursement.

GOOD FAITH ESTIMATE: You and your counselor (by collaborative agreement) will plan and determine the best course of treatment for your specific circumstance, which includes the number of counseling sessions you will need. You can estimate the cost of your treatment by simply multiplying the number of sessions by the hourly counseling fee. In other words, there will be no unexpected costs or surprises. For example: if you need five (5) counseling sessions, your total cost will be $500. You and your counselor may determine that you need more than or fewer than the number of sessions you estimated at the beginning of treatment, but you will always have the freedom to terminate, continue, or extend counseling at any time.

CANCELATION: At least **24 hours-notice** is required for cancellation. If a scheduling emergency occurs, the client is to contact the counselor as soon as possible. If adequate notice is not provided, or the client is a "no show" for the scheduled appointment, the client will be billed the entire session amount for the missed appointment.

_____ _____

PRINTED: Client Name SIGNATATURE: Client Date

INFORMED CONSENT & AUTHORIZATION TO TREAT

The following information is for your benefit so you can enter a cooperative counseling partnership in an informed manner. Counseling is a helping relationship for which you are voluntarily entering for assistance with specific and stated problems. It is expected that you will benefit from your counselor relationship, but there are no guarantees that you will. Keep in mind that it is common to feel worse before feeling better. It is also expected that the counseling relationship should end through mutual agreement once desired goals have been reached; however, you have the right to terminate counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

By law, the counselor considers all information and issues presented in the course of counseling as privileged and confidential. Confidential information may be released only with the written consent of the person being treated or that person's legal guardian. State law also requires the release of confidential information 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 age 18) and reports suspected child abuse or neglect, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may require court-ordered counseling records, a deposition or testimony from a counselor. The contemplation, commission of a crime or harmful act is not considered confidential communication.

Consultation, Professional Training and Clinical Supervision

In accordance with legal and ethical standards, the counselor may be required to participate in direct supervision. The counselor requires your consent to obtain professional supervision or collegial consultation outside this practice when he/she feels it will facilitate the work with the client or the client's family. The client's name and any uniquely identifying information about the client or his/her family will be deleted or changed to protect identity.

The client's signature on this form indicates the client's consent for consultation, training and supervision.

Professional Records

The laws and standards of counseling require the keeping of case records. Records are locked and kept on site, or stored electronically through a secure cloud service. The client is entitled to receive a copy of his/her records or a summary of the client's care per a written request These request forms for the summary care are available from the counselor. Please note that these are professionally-held records and can be misinterpreted and/or upsetting to untrained readers. If a client wishes to receive his/her records it is recommended that they be reviewed with the counselor so that the contents can be discussed. The client has the right to amend the record, if he/she finds something disagreeable or concerning. Client records will NOT be disclosed to others unless the clients requests the counselor to do so in writing, or unless the law compels the counselor to do so. Communications between the counselor and client will otherwise be deemed privileged and confidential as stated under the laws of this state. The client will be charged an appropriate fee for any professional time spent in responding to requests for information. Meetings will be scheduled at mutually convenient times.

In the unfortunate event of a counselor's inability to continue care (e.g., extended illness, termination, retirement, death) the client's records will be transferred to another counselor, or to a trustee so designated by the practice, who will consult with the client as to referral options for continuation of care.

Authorization for Treatment

My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my counseling for specific and stated problems.

_____ _____

PRINTED Client Name SIGNATURE Client Date

PRIVACY PRACTICES NOTICE (HIPAA - FEDERAL LAW)

INTRODUCTION
This notice contains summary information about the **Health Insurance Portability and Accountability Act** (HIPAA), a Federal Law that provides privacy protections and patient rights regarding the use and disclosure of a patient's Protected Health Information (PHI). Desert Therapies and Wellness is dedicated to maintaining the privacy of your PHI as part of providing professional care and are required by law to keep your information private. The Federal Law requires that we obtain each patient's signature acknowledging that we have provided this information.

PROTECTED HEALTH INFORMATION (PHI)
Protected Health Information (PHI) is any information that is collected about patient's health conditions, treatment or any information that could identify the patient. PHI includes any information - verbal, recorded, written or electronically transmitted. In this office, PHI is likely to include but not limited to: your personal history and demographic information; reasons you came in for counseling; diagnoses; treatment plan; progress notes; records we get from others who treated you or evaluated you; information about medications you took or are currently taking; billing and insurance information.

The Law states that this information **can only be used or disclose if the patient signs a written authorization**. There are other situations that require only that the patient provide written, advanced consent, and the patient's signature on this agreement provides that consent for those activities as outlined in this notice. If any disclosure is needed beyond what is listed in this notice, a patient will be asked to sign a separate Release of Information Form before any PHI is disclosed.

USES OF PHI UNDER HIPAA
The HIPAA law allows for the following disclosures of a patient's PHI to an outside entity for the following purposes:

- Treatment: Providing, coordinating or managing a patient's health care and other services related to your healthcare. For example, coordinating care with your Primary Care Physician.
- Payment: Obtaining reimbursement for a patient's healthcare or billing a patient for services rendered.
- Health Care Operations: Activities that relate to the performance and operations of this practice. Which may include: quality assessment and improvement activities, audits, administrative services and clinical peer review.

LIMITS OF CONFIDENTIALITY

- If a therapist believes a child has been the victim of injury, abuse, neglect or deprivation of necessary medical treatment, the law requires that the therapist make a report to the appropriate law enforcement authority. Once such report is filed, the therapist may be required to provide additional PHI information.
- If the therapist believes that any adult patient who is either vulnerable and/or incapacitated has been the victim of abuse, neglect, or financial exploitation, the law requires that a report be filed with the appropriate state official.
- If a patient communicates an explicit threat of imminent, serious or physical harm, to a clearly identified or identifiable victim, and the therapist believes that the patient has the intent and ability to carry out such a threat, the therapist must take protective actions that may include notifying the potential victim, contacting law enforcement, or seeking hospitalization for the patient. Additionally, if the patient threatens harm to him/herself the therapist may be obligated to seek hospitalization for patient or to contact family members or others who can help provide protection.
- A therapist may occasionally find it helpful to consult with other healthcare and mental health professionals about a case. During a consultation, every effort will be made to avoid revealing the identity of a patient. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in the patient's Clinical Record.

- If a government agency is requesting information for health oversight activities, a therapist may be required to provide it for them.
- If a patient files a complaint or lawsuit against a therapist, relevant information regarding that patient may be disclosed in order to defend against the suit or complaint.
- If a patient files a worker's compensation claim and a therapist is providing services related to that claim, the therapist must, upon appropriate request, provide appropriate reports to the Worker's Compensation Commission or the insurer.
- If the patient is involved in a court proceeding and a request is made for information concerning the professional services provided to them, such information is protected the laws of therapist-patient privilege. A therapist cannot provide any information without the patient's or their legal representative's written authorization, or a court order. If the patient is involved in or contemplating litigation, he/she should consult with their attorney to determine whether a court would be likely to order such disclosure.

MINORS AND PARENTS

Patients under the age of 18 years of age, who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes the therapist's policy to request an agreement from parents that they consent to give up access to their child's records. If they agree, during treatment the therapist will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. The therapist will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless the counselor believes that the child is in danger or is a danger to someone else. In which case the therapist will notify the parents of the concern. Before giving parents information, the therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections the child may have.

PATIENT RIGHTS

HIPAA provides the patient with several explained rights regarding Clinical Record and disclosure of Protected Health Information. These rights include:

- Patients have the right to restrictions on specific uses and/or disclosures of their PHI. However, therapists are not required to agree to a restriction that a patient requests.
- Patients have the right to inspect and/or obtain a copy of PHI in mental health and billing records. Therapists may deny your access to PHI under certain circumstances.
- Patients have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Therapist may deny your request if they believe the original information is accurate.
- Patients have the right to request an accounting of disclosures that Daniels and Associates, LLC has made of your PHI. Some exceptions do apply.
- Patients have the right to determine the manner and location to which PHI is sent. This includes appointment reminders and billing statements.
- Patients have a right to have any complaints about a therapist's policies and procedures recorded in their record.

By signing below, I indicate that I have read the Privacy Practices Notice and understand the information contained and have been offered a copy of the Notice.

_____	_____	
PRINTED Client Name (Guardian if under 18)	SIGNATURE Client (Guardian if under 18)	Date
_____	_____	
PRINTED Client Name (Guardian if under 18)	SIGNATURE Client (Guardian if under 18)	Date