

# Desert Therapies and Wellness

## Counseling and Wellness

7739 E. Broadway, St. 324 Tucson AZ 85710

### CLIENT INFORMATION – MINOR CHILD (TO BE COMPLETED BY PARENT OR GUARDIAN)

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M / F

#### Mother's/Guarding Information:

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

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

City, State, Zip: \_\_\_\_\_

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

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

Parents are (please circle):      Married      Separated      Divorced      Never Married

Child lives with (please circle):    Both    Mom    Dad    Guardian    Other: \_\_\_\_\_

**Note: If child's parents are divorced, state law requires that the signed consent of both parents or have a custody agreement on file before the child can be seen by a therapist. NO EXCEPTIONS.**

Please list names and ages of siblings: \_\_\_\_\_

\_\_\_\_\_

If parents are remarried or living with someone else, please give names and ages of step-family members: \_\_\_\_\_

\_\_\_\_\_

To which relatives does the client feel closest and why? \_\_\_\_\_

#### Developmental History

Please describe any developmental delays or regressions (sleep difficulties, bed wetting, thumb-sucking, toilet training, etc.): \_\_\_\_\_

\_\_\_\_\_

Does the client have any particular fears? Please describe: \_\_\_\_\_

\_\_\_\_\_

Has the client suffered any recent traumas or losses? (death of loved one/friend/pet, recent move, etc.):

\_\_\_\_\_

What special interests or hobbies does the client have? \_\_\_\_\_

\_\_\_\_\_

**Educational Information**

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Did the client have any difficulty starting or continuing in school and if so, please describe? \_\_\_\_\_

How does the client do academically? \_\_\_\_\_

How does the client do socially? \_\_\_\_\_

To which friends does the client feel closest and why? \_\_\_\_\_

Describe any school problems: \_\_\_\_\_

What kinds of discipline have been used with the child? \_\_\_\_\_

**Medical Information**

Is client taking any medication or supplements? Yes No

If yes, please list: \_\_\_\_\_

Please list any past or present health issues, including pain, the child has experienced? \_\_\_\_\_

Please describe the child’s current habits regarding nutrition and exercise: \_\_\_\_\_

Has the child ever had weight/growth problems? Yes No

**Mental Health Information**

Has the client sought help in counseling or psychotherapy before? Yes No

If so, when and with whom? \_\_\_\_\_

Has the client ever been diagnosed with any mental health condition? Yes No

Please list (for example, ADD, ADHD, Anxiety, etc.): \_\_\_\_\_

**Abuse Information**

Is the client exposed to any substance use/abuse? Yes No

If yes, please describe: \_\_\_\_\_

Has the client experienced physical, sexual or emotional abuse? Yes No

If yes, please describe: \_\_\_\_\_

**Spiritual Information**

Does the child have any spiritual or religious background? Yes No  
Does the child or his/her family currently practice any type of religion or spirituality? Yes No  
Please describe: \_\_\_\_\_  
Is the child currently active in a local church or community of faith? Yes No  
Congregation: \_\_\_\_\_  
How often does the child or family attend? \_\_\_\_\_

**Presenting Concerns**

Please describe the problem for which you are seeking counseling for the client? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What changes would you like to occur as a result of counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
PRINT NAME: Parent/Guardian

\_\_\_\_\_  
SIGNATURE: Parent/Guardian Date

\_\_\_\_\_  
PRINT NAME: Parent/Guardian

\_\_\_\_\_  
SIGNATURE: Parent/Guardian Date

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### FINANCIAL AGREEMENT

Counseling fees (individual, couple, family and EMDR) are \$100 per 50-minute session. I do accept ESA payments. I can also provide a super bill for Insurance reimbursement.

Payment is expected at the time of service unless other arrangements have been made.

Accepted method of payments include: cash, credit, debit, HSA card or personal check. Checks are to be made payable to Desert Therapies and Wellness.

Health Insurance. I 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.

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: Parent/Guardian

\_\_\_\_\_  
SIGNATURE: Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
PRINTED: Parent/Guardian

\_\_\_\_\_  
SIGNATURE: Parent/Guardian

\_\_\_\_\_  
Date

## INFORMED CONSENT

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 and Professional Training**

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.**

### **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 within the practice, or to a trustee so designated by the practice, who will consult with the client as to referral options for continuation of care.

**AUTHORIZATION TO TREAT**

**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: Parent/Guardian

\_\_\_\_\_  
SIGNATURE: Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
PRINTED: Parent/Guardian

\_\_\_\_\_  
SIGNATURE: Parent/Guardian

\_\_\_\_\_  
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 Desert Therapies and Wellness 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
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PRINTED Client Name (Guardian if under 18)	SIGNATURE Client (Guardian if under 18)	Date
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Client Name: \_\_\_\_\_