Integrative Psychotherapy and Assessment Services

PHOENIX LOCATION UPDATED Code To Enter Reception Door: Provided in your intake email.

While the intake paperwork is rather lengthy, it is important to obtain a thorough assessment. Also, the documents contain information related to federal laws put into place to protect you.

Please be aware that we have a 24 hour cancellation policy. For our initial therapy appointments, a $25 cancellation fee is in place if an appointment is not canceled with a 24 hour notice. All appointments thereafter are subjected to the session fee of $100.00 ($25 intern; $40 prelicensed provider) if not canceled with 24 hours' notice. Cancellations need to be conducted during business hours.

Cash is a preferred method of payment; however, we accept credit card, debit card, and apple pay.

IPAS is located at:

Phoenix location:

2102 W Bethany Home Rd. Phoenix, AZ 85015

(gray building on the north west corner)

Phoenix Parking: You may park on the street, compact cars may park in the small parking lot north of building, compact cars may park on the east side of the building. Please don't block the sidewalk or you could receive a ticket.

Mesa Location:

1136 E. Harmony Ave Suite 202 B. Mesa, AZ (In the Stapley Executive Center)

SECOND FLOOR-NO HANDICAP ACCESS

Please feel free to call us with any questions or concerns you may have at 602-774-4745

If the client is a minor- both parents need to give consent. If there is a medical decision-making court order, we need to be provided a copy before your intake appointment.

As required by some insurance companies for IPAS to ask: if you have advanced directive or end of life documentation, please provide for your medical file. If you have any previous mental health records or assessment, please provide a copy for your medical file.

Thank you very much for booking with us and we look forward to working with you!

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to our practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. We request no video or audio recording of sessions.

MEETINGS

I normally conduct an evaluation that will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 53-minute session (one appointment hour of 53 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If you no show for the initial appointment, or have 2 consecutive no shows to scheduled appointments, services will be terminated and referrals given to you and/or your Case Manager. After three unconsecutive no shows or late canceled appointments throughout treatment, services will be terminated and referrals given to you and/or your case manager. Medicaid clients will pay the missed appointment fee set by the state.

PROFESSIONAL FEES

My session/hourly fee is: intake $225 ongoing session: $175 (intern $25.00; prelicensed $40). In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $300 per hour for preparation

and attendance at any legal proceeding. The fee amount is to be paid at least 5 days prior to the court date and a half day retainer is a common minimum.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by my voice mail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I also have contracts with medical billing services. As required by HIPAA, I have a formal business associate contract with this/these business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your or your legal representative's written authorization, or a court order. If you are involved in or

contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, and I am providing services related to that claim, I must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child under 18 who I have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that I file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and I believe that the patient has the intent and ability to carry out such threat, I must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you

initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee and other appropriate charges for my time spent preparing these documents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 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 treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I 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 I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it

is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

If you are using an authorization for services, you are responsible for keeping track of your authorized number of sessions or authorization end date. Any services you schedule outside the number allowed sessions or the dates approved, you are responsible to pay for.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the

right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes and summaries.

You agree to the above limits of confidentiality and understand their meanings and ramifications.

INSURANCE INFORMATION

As a convenience to you, we can bill your insurance company for the services we provide. You are financially responsible for charges that are not covered under your insurance plan.

All required copayments, coinsurance and deductibles are due at the time of service or when we receive benefit statements or remittance advices from your insurance company.

Providing complete and accurate insurance provider information on your first visit is essential.

If you have questions about your authorizations, coverage, copays, or deductibles, please call you insurance company.

Primary Insurance Company

Company Name:

Policy ID:

Group No.:

Plan Name:

Insured’s Employer/School:

Policy Holder’s Name:

Policy Holder’s Date of Birth:

Policy Holder’s Address:

City:

State:

Postal Code:

Secondary Insurance Company (if applicable)

Company Name:

Policy ID:

Group No.:

Plan Name:

Insured’s Employer/School:

Policy Holder’s Name:

Policy Holder’s Date of Birth:

Policy Holder’s Address:

City:

State:

Postal Code:

Please take a picture of your insurance card(s) with your phone and upload the file(s) using the Insurance Card option on the left side of your portal. If you can't upload a your card(s), be sure to bring your insurance card(s) or a photo copy of the front and back of the card(s) to your first appointment.

Employee Assistance Program (EAP) (if applicable)

Do you have employee assistance program benefits through your employer? Yes No

If yes, what is the name of the EAP provider? :

Authorized Sessions:

Authorization Number:

Authorization Start Date:

Please bring a copy of the EAP Provider’s authorization letter to your first appointment. Your EAP Provider can also fax a copy of the authorization to us at 602-449-0032.

INFORMED CONSENT FOR TELEPSYCHOLOGY AT INTEGRATIVE PSYCHOTHERAPY AND ASSESSMENT SERVICES

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. Should we become disconnected due to a technology failure, I request you re-enter the online clinic. Should we continue to have technology issues, I will call you at the number listed on your profile to complete any needed discussion. If I am unable to reach you by phone call or by logging into the platform I will use the alternative means to reach you that you list at the end of this document.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work. Should an emergency situation arise when I am not available, the required procedure is for you to go to the closest emergency room, call 911, or call Empact crisis at 480-784-1500 .

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology. I request you log into my **HIPAA compliant Telehealth/**online clinic and keep your login information private for confidentiality.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency. Your signature below allows email or text message usage as described above.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone at 602-774-4745. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The manner of identifying you when we use communication that does not involve video is for you to state your birthdate at the start of the session.

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to “check-in” with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Your location of services is assumed to be at your home address on file. If you are not going to be at the provided home address for your session, you will need to notify the provider at the start of the session of your location.

It is imperative the use of telepsychology is consistent with your knowledge and skill regarding use of the technology involved in providing psychological service by telepractice or with ready access to assistance with use of the technology and your best interest.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we may create

an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you.

If there is a technological failure and we are unable to resume the connection, your insurance will only be charged the prorated amount of actual session time and the client will be responsible to pay for the remainder time they reserved for their session. Technological issues due to the provider's technology will not be reimbursed for.

Sources for Face to Face Emergencies: local emergency room; Aurora Behavioral Health(480-345-5400); Quail Run Behavioral Health (602-455-5700); St. Luke's Behavioral Health (602-251-8535; Oasis Behavioral Health (480-470-0069); Valley Hospital (602-957-4000)

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. When a telepsychology session is established, you will identify yourself by stating your date of birth and stating your name.

Your signature indicates agreement with its terms and conditions.

You are required to provide an emergency contact and alternative means to reach you (email, text, fax, mail, etc). Should I not be able to reach your emergency contact or you do not provide an emergency contact, you understand that my call may be to the local police department, crisis support team, or the VA hospital, if you are a veteran (face to face emergency services). You are welcome to give me more than one emergency contact.

Name of Emergency Contact:

Phone Number of Emergency Contact:

Alternative means to contact you(other than phone):

Alternative means to contact me: office 602-774-4745; my email address; mail: 2102 W Bethany Home Rd; Phoenix, AZ 85015; General mailbox: info@PhoenixPsychologists.com

Informed Consent for Supervision

The purpose of this letter is to help clarify what to expect about the counseling process and how to make it as effective as possible.

What you say to me is confidential, however there are some limitations to that confidentiality. All clinicians, clinicians in training, and their supervisors will not disclose information except under the following conditions:

- The client or guardian gives written consent to release information to a designated individual or agency.
- The client makes specific violent threats to harm themselves or to harm an identifiable victim.
- The clinician and/or their supervisors are named as defendants in a civil, criminal, or disciplinary action arising from the counseling session.
- The clinician receives an authentic subpoena backed by judicial authority that requires the disclosure of information.
- The clinician has reasonable cause to believe that a child or an adult with a disability has suffered abuse or neglect.
- The clinician will discuss the content of counseling sessions and individual and group supervision under the direction of a qualified supervisor who has the same professional standards of confidentiality and its limits.

It is also important for you to know that I work under direct supervision and clinical supervision by a licensed behavioral health professional. My clinical supervisors' names are: Tiffany Tschantz, Dr. Dawn Byrd, and or Steve Stiel. She/He can be reached at 602-774-4745.

I will be meeting with the clinical supervisor and discussing your case and records on a regular basis. This is to receive feedback and guidance on how to best pursue your case and to meet requirements for the licensure of the Arizona Board of Behavioral Health Examiners. If you have any questions or concerns regarding this process, feel free to contact the above supervisor.

By signing this form, you are stating that you have gone over this information with your therapist and understand the counseling process and the confidentiality standards at Integrative Psychotherapy and Assessment Services.

Informed Consent for Supervision

Please initial next to the following statements:

I have been informed that the provider I will be seeing is a graduate student with Grand Canyon University and is under the supervision of Dr. Dawn Byrd, Tiffany Tschantz, and or Steve Stiel.

I understand all information provided to the provider can and will be shared with any of the supervisors. This includes information provided orally and in writing. I understand that my case is supervised and will discuss treatment for me with the provider.

____I understand Dr. Byrd will review and sign off on all of my clinical records.

_____ I agree to notify Dr. Byrd, Steve Stiel, or Tiffany Tschantz with any questions or concerns regarding my treatment.

_____ I understand that all of my billing is cash pay.

I agree that my sessions can be recorded (audio and visual), in order to aid in the supervision process and to provide me the best care possible.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing

claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a mental health professional, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA. There are additional HIPAA forms for your review on our website at www.PhoenixPsychologists.com and in office.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person

identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will

be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at [Name of Officer] at [Address, City, State, Zip Code].

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also

request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

HIPAA Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client's Name: Client Representative's Name: (if applicable)

Client's DOB:

Client's SSN: (Medicaid and Medicare only)

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

I hereby acknowledge that I have received and have been given an opportunity to read a copy of this Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer, [officer name] at [address, city, state, postal code] or [phone number].

Acknowledge Receipt: Yes No

A copy of this notice will be available to you in your documents section of our Client Portal.

Fee Schedule

Initial Assessment/Intake Appointment: $225

Therapy/Office Visit: $175 per session (Practicum Student or Intern: $25.00; $40 for prelicensed provider)

Psychological Evaluation: Testing/Report writing/Record Review $250 per hour

(Flat rate psychological evaluations can be discussed)

Gifted Testing Evaluation and report writing: FSIQ plus 3 areas of gifted $500, $425 for 3 areas, $300 for 2 areas, and $225 for one area

Telephone Consultation/School Advocacy consultation: Telephone Call $50 for 30 minute

School Advocacy/meeting attendance at the school: $175 per hour

Email correspondence with parents teachers, etc lasting longer than 5 minutes: $175 per hour

Return Check fee: $25.00 per occurrence

Late cancellation/missed appointments: session fee of $100.00 (Practicum Student or Intern: $25.00; Prelicensed: $40)

Fax received over 5 pages: $.50 per page

Copies mailed over 5 pages: $.50 per page plus $4.00 postage

Record requests: $.50 per page over 5 pages

Legal proceedings: $300.00 per hour

Letter writing, documentation preparation, telephone conversations lasting 5 min or more, consultation with other professionals on your behalf, preparation of records, treatment summaries, and time spent performing any other services asked of me: $175.00 per hour.

I understand there is a charge for missed or canceled appointments that do not provide a 24 hour cancelation notice. I understand my card on file will be charged during the scheduled appointment time.

By my signature I acknowledge receipt of this letter, reading the above financial terms, and I agree to the above financial terms.

Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Voicemail

I will leave voicemail with your permission if I need to confirm a future appointment or in regards to any administration issues such as billing, scheduling, termination of services, or insurance.

opt out of voicemail permission

Email and Text Communications

I use email communication and text messaging only with your permission and only for administrative purposes, scheduling, billing, or termination of services unless we have made another agreement. If you email me, we take this as permission to email you back. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

____opt out of email communication completely

____opt out of email communication but appointment reminders via email are acceptable

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together and terminate the connection. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

Credit Card Payment Consent

Client Name

Name on card if different than above

I authorize Integrative Psychotherapy and Assessment Services to charge my credit card for professional services as follows:

All visits in the next 12 months (session fee is $175.00)

Document preparation (hourly fee of $175.00)

No show or late cancel fee (session fee is $100.00). The policy is strictly enforced.

The balance not paid by my insurance company. We do not call in advance, please check your explanation of benefits sent to you by the insurance company when your claim is processed for explanation of fees.

Should your card be charged for a financial obligation defined by your insurance company and you request a claim review, your card will be refunded after the claim review shows a change in financial obligation.

Type of Card:

Card Number:

CVV Number:

Expiration Date:

Card Holder's full billing address for credit card statements:

Cancellation Policy

Integrative Psychotherapy and Assessment Services requires at least 24 hours in advance notice for cancellations of an appointment. If 24 hours notice is not given, you will be charged a late cancellation fee of $100.00.

Thank you for your consideration regarding this important matter.

Adolescent & Child Intake Information

Please provide the following information and answer the questions below. Please note: Information you provide is protected as confidential information.

GENERAL INFORMATION

1. Client's Name:

(First Name) (Middle Initial) (Last Name)

Client's Address: City: State: Zip Code:

Client's Date of Birth: Age: Gender: Male Female

2. Parent's Names: (include step-parents, foster parents, etc.)

Parent Name:

(First Name) (Middle Initial) (Last Name)

Cell Phone: Cell Carrier Name: May we leave a message? Yes No

E-mail Address: May we email you? Yes No

Parent Name:

(First Name) (Middle Initial) (Last Name)

Cell Phone: Cell Carrier Name: May we leave a message? Yes No

E-mail Address: May we email you? Yes No

3. Natural Child: Yes No If adopted, at what age: Foster since what date:

Comments about custody & visitation (if applicable)

4. Primary reason you are concerned about your child?

SYMPTOM/PROBLEM CHECKLIST

Check any symptom or problem that is a concern. How long has it been a problem?

	Sleep problems		Morbid thoughts
	Lack of interest in activities		Suicidal thoughts or threats
	Unassertive		Suicidal plans / attempts
	Fatigue / Low energy		Mood swings
	Concentration problems		Depression
	Appetite / weight changes		Changed level of activity
	Withdrawal		Cries easily
	Forgetful / memory problems		Talks excessively / interrupts
	Short attention span		Easily distracted
	Aggressive behavior		Irritable
	Can't sit still		Impulsive
	Not interested in peers		Difficulty following rules
	Picked on / bullied by peers		Problem completing schoolwork
	Excessive worry / fearfulness		Nightmares
	Anxiety or panic attacks		Frequent tantrums
	Social fears, shyness		Resistive to change
	Separation problems		School refusal
	Bedwetting / soiling		Perfectionism

	Headaches, stomachaches		Odd hand / motor movement
	Odd beliefs / fantasizing		Hallucinations
	Lying		Stealing
	Trouble with the law		Being destructive
	Running away		Fire setting
	Truancy / skipping school		Hurting others / fighting
	Hurting others sexually		Acts as if has no fear
	Alcohol / drug use		Short tempered
	Argumentative / defiant		Easily annoyed/annoys others
	Swears		Discipline problem
	Blames others for mistakes		Angry and resentful

Comments Related to Symptoms or Problems

BROTHERS and SISTERS

Please include each child's first name, last name, gender, age and relationship to client: (full, step, half, foster)

Please list any other family members living in the same household (if any)

Please list other unrelated people living in the same household (if any):

Emergency Contact Name: Relationship to Contact:

Primary Phone: Secondary Phone:

SCHOOL HISTORY

1. Present School Name: Grade:

2. Has your child ever repeated any grade? No Yes

3. Is your child receiving special education services? No Yes If so what kind?

4. Please describe academic or other problems your child has or has had in school?

DEVELOPMENTAL HISTORY

Mother used during pregnancy: alcohol drugs cigarettes none _____

Delivery: Normal Breech Cesarean Birth weight: lbs. ounces

Full-term Premature If premature, number of weeks

Problems at birth: (for example: infant given oxygen, blood transfusion, place in an incubator, etc.)

State approximate age when child did the following:

Walked alone Said first word Used 2-word phrases

Understood and followed simple directions

Reasonably well toilet trained

Did child cry excessively? No Yes

Rarely cried No Yes

In the first two years, did your child experience:

Separation from mother No Yes, Out of home care No Yes, Disruption in bonding No Yes

Depression of mother No Yes, Abuse No Yes, Neglect No Yes, Chronic pain No Yes

Chronic Illness No Yes, Parental Stress No Yes, Any head injuries or loss of consciousness? No Yes

MEDICAL HISTORY

Current Medical Conditions:

History of medical treatments, serious illness, injury, handicaps, or hospitalization?

Does your child have a Primary Care Physician? No Yes Physician's Name:

Has your child previously received any type of mental health services

(psychotherapy, psychiatric, etc.)? No Yes

If yes, please describe:

Is your child currently taking any medications? No Yes If yes, please list:

Medication Name: How Long?

Medication Name: How Long?

Medication Name: How Long?

Has your child ever been prescribed psychiatric medication? No Yes . If yes, please list:

Medication Name: Dates: to

Medication Name: Dates: to

List any medicines previously used for emotional problems:

Medication Name: How Long?

Medication Name: How Long?

Allergies to drugs or medicines? No Yes (list)

Allergies to any foods? No Yes (list)

Describe allergic reactions to drugs, medicines or foods:

Are there any foods that you limit or do not give this child? No Yes (list)

Allergies to environmental conditions? No Yes (list)

Does anyone in the household smoke? No Yes

About how many hours does this child watch TV, videos, play video games, etc. per day

Are you afraid someone you know may injure/harm this child? No Yes

Does this child have a Health Care Directive? No Yes If yes, please list where you keep the directive:

Any previous testing (school/psychological)? No Yes

If yes, Whom/Where/When:

Do you think your child's use of chemicals is a problem? No Yes

Type: Alcohol Marijuana Other drugs

Comments:

Has your child had any history of self-harm or suicidal attempts? No Yes

Describe if applicable:

FAMILY MENTAL HEALTH HISTORY

In this section, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex. Father, grandmother, uncle, etc.)

Family Member(s)

Alcohol/Substance Abuse: No Yes

Anxiety: No Yes

Depression: No Yes

Domestic Violence: No Yes

Eating Disorders: No Yes

Obesity: No Yes

Obsessive Compulsive: No Yes

Schizophrenia: No Yes

Suicide Attempts: No Yes

Self-Harm: No Yes

Comments related to Family Mental Health History:

LIFE STRESSORS/TRAUMA HISTORY

Has your child ever been a victim of physical abuse? No Yes Suspected

Specify:

Has your child ever been a victim of sexual abuse? No Yes Suspected

Specify:

Has your child ever experienced significant trauma? No Yes Suspected

Specify:

Other stressors or traumas?

ADDITIONAL INFORMATION

1. Is your child currently employed? No Yes

   If yes, what is your/your child current employment situation?

2. Do you consider your child to be spiritual or religious? No Yes

   If yes, describe your/your child's faith or belief:

3. What do you consider to be some of your child's strengths?

4. What do you consider to be some of your child's weaknesses?

5. What would you like to accomplish during your child's time in therapy?

6. Any additional comments or information that would be helpful to us?

Person completing this form: Relationship to child:

Your signature indicates that you understand and agree to all terms within this intake document for mental health service.

If there are medical decision making records, please provide them prior to starting services.

_____ Date:_____

_____Print Name