Client Information (Child Age 11 – 17)

Date: _____

I am seeking: ☐Individual Counseling ☐Couples Counseling ☐Group Therapy ☐Other: _____

How did you hear about us? ☐Internet ☐Word of Mouth ☐Attended a Presentation ☐Insurance ☐Other

Client Information	Relationship Status
Name: _____ Date of Birth: _____ Address: _____ City: _____ State: _____ Zip: _____ Main Phone: _____ Alt Phone: _____ Email: _____ □ ***I do not*** want to be added to Yuma Counseling Service's email list	**How many people live in your household?** _____ Who lives with you?
Employment Information	**Health and Medical**
☐Employed ☐ Unemployed ☐Student	Primary Care Physician: _____ Phone: _____ Psychiatrist: _____ Phone: _____

Emergency Contact

Notify: _____ Phone:_____

Relationship to Client:_____

Insurance Information Contact

Health Insurance Name:		**Insured ID Number:**	
Insurance Plan Name:		**Insured Group Number:**	
Client Relationship to Insured:	□Self □Spouse □Child □Other:	**Insured Phone:**	
Insured's Name: (Last Name, First Name)		**Insured Date of Birth:**	
Insured's Address: (If different than above)			
Employer or School:			

By signing below, you authorize payment of medical benefits to Yuma Counseling Services and give permission to Yuma Counseling Services to provide needed information to your insurance company to process your claims.

X_____ **X**_____ **X**_____

Signature of Client or Authorized Person **Printed Name** **Date Signed**

Financial Responsibility Statement

Your signature below indicates that you accept full responsibility for all fees due to professional services and that you realize that any third-party billing (billing your insurance) is out of courtesy to you and does not transfer any financial responsibilities for unpaid services.

DEBIT/CREDIT CARD AUTHORIZATION Terms: We have a 24-hour cancelation policy. If you cancel later than the 24 hours, your card will be charged according to our late fee policy. If you do not show for your scheduled appointment, you will be charged the regular session fee as well. Please be considerate of your therapist's time. If you notify us before 24 hours, it will allow us to schedule other clients seeking services at Yuma Counseling Services.

In order to keep your credit card information secure, we enter your card directly into our security compliant software. Please provide the card you wish to use to the receptionist.

Name on the Card: _____

For which client(s): _____

Last 4 digits of Credit Card: _____

Billing Address: _____
Address City/State Zip

I, the undersigned hereby authorize Yuma Counseling Services, PC, to charge the above-referenced credit card for services rendered, missed appointments that were not cancelled with more than 24-hours notice, or co-pays. Receipts are available upon request.

In addition, I understand my credit card will be charged in the event a check is returned for insufficient funds.

I, the undersigned, understand that it is my responsibility to inform Yuma Counseling Services, of any changes to my credit card information including address, zip code, updated expiration dates, account numbers and security codes. I understand I will be responsible for any bank chargeback fees in the event that this information is not kept up to date.

We will be unable to provide services without a credit card on file.

_____ _____
Signature Date

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 social worker licensed in this state and as a member of the National Association of Social Workers, 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.

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 928-276-9535:

- **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 at 928-276-9535 or 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.**

The effective date of this Notice is Aug 2018.

Grievance Procedure

If at any time, I am unhappy with the care I am receiving, I understand that I am encouraged to talk to my therapist about my concerns. I am aware that should I file a grievance, I need to submit my concerns in writing to Yuma Counseling Services so that they may be promptly addressed. Additionally, I am aware that I am free to contact the following agencies to report concerns about the care I am receiving:

-Arizona Center for Disability Law:
3839 North Third Street Suite 209
Phoenix, AZ 85012
602-274-6287

-Arizona Board of Behavioral Health Examiners:
3443 North Central Avenue #1700
Phoenix, AZ 85012
602-542-1882

Arizona Department of Health Services:
150 N 18th Avenue
Phoenix, AZ 85007-3245
602-542-1025

Client Rights

A client has the following rights:

1. To be treated with dignity, respect, and consideration
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment
3. To take part in treatment that supports and respects individuality, choices, strengths and abilities
4. Client's personal liberty are supported and only restricted according to a court order; by the client's general consent; or as permitted by law.
5. Treatment is provided in the least restrictive environment that meets client's treatment needs.
6. To be part of their treatment planning and decision-making process including being informed of proposed treatment including the risks of treatment
7. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights
8. To submit grievances or concerns to agency staff or appropriate agencies without constraint or retaliation and to have the grievance considered by a licensee in a fair , timely and impartial manner
9. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense
10. Receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
11. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;
12. To have the client's information and records kept confidential and released only as permitted by law
13. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
    a. For photographing for identification and administrative purposes, as provided by Arizona statute
    b. For video recordings used for security purposes that are maintained only on a temporary basis
    c. Or when giving specific written consent for training purposes
14. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in Arizona Statute R9-20-211(A)(6);
15. To review the following at the agency or at the Department:

a. Arizona State Statutes
b. The report of the most recent inspection of the premises conducted by the Department;
c. A plan of correction in effect as required by the Department;
d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and
e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;

14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis;
15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;
16. To be offered or referred for the treatment specified in the client's treatment plan;
17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;
19. To be free from:
    a. Abuse;
    b. Neglect;
    c. Exploitation;
    d. Coercion;
    e. Manipulation;
    f. Retaliation for submitting a complaint to the Department or another entity;
    g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
    h. Treatment that involves the denial of:
        i. Food,
        ii. The opportunity to sleep, or
        iii. The opportunity to use the toilet; and
        i. Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
21. To control the client's own finances except as provided by A.R.S. § 36-507(5);
22. To participate or refuse to participate in religious activities;
23. To refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene;
24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;
25. To participate or refuse to participate in research or experimental treatment;
26. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;
27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility

Yuma Counseling Services

Consent to use and disclose your Health Information

This form authorizes Yuma Counseling Services to disclose Protected Health Information (PHI) as outline in the Notice of Privacy Practices.

If you do not sign this consent form agreeing to our Notice of Privacy Practices, we cannot treat you.

If you are concerned about some of your information, you have the right to ask us not to share some of your information for treatment, payment, or administrative purposes and will need to tell us what you want in writing. We will try to accommodate your requests; however, we are not required to agree to these limitations, but if we do agree, we will honor our agreement unless we are unable to by law.

After you have signed this request, you can revoke your consent in writing. We will comply with your request from that point forward but will be unable to change or revoke the information that has already been shared. Please be aware that if you revoke your consent, we will be unable to continue providing treatment or services to you.

By signing below, I agree to let Yuma Counseling Services, PC share my PHI to others as outlined in the Notice of Privacy Practices. I hereby acknowledge that I have received and have been given a copy of Yuma Counseling Service's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Troy Love, President, at 928-276-9535.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative * Date

_____

* 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.).

Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date

Office Policies

Appointments:

Appointments are usually scheduled for **45 - 60 minutes**. If you require longer sessions, please discuss this with your therapist. You and your therapist will also discuss how often it is recommended that you be seen. Please remember that you may discontinue treatment at any time. Phone sessions are billed at the same rate as face-to-face sessions.

Fees:

The fee for individual and/or family counseling services **for a 45 – 55-minute session** is **based on a sliding scale fee or as agreed upon with your insurance provider**. Longer sessions will be billed based on the duration of the session (e.g., 1 ½ hours = $195). Fees may be paid with cash, check, or credit card.

If you have out-of-network benefits, your insurance may reimburse you for a portion of this fee. We will provide you with a statement with which you may bill your own insurance for reimbursement.

Record Keeping:

It is required that a clinical record be maintained that includes assessments, treatment plans, dates and times of therapy sessions, and notes describing your progress. Records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section below. Clinical records are maintained in a secured manner that complies with HIPAA regulations. You may receive a copy of your records if you make a formal written request and pay a $50 retrieval fee. Please be advised that it may take up to 30-days to receive your records from the day your request is obtained. If your therapist determines it would not clinically be in the client's best interest to receive the complete records, a summary of the notes will be provided instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your psychotherapist or have them forwarded to another mental health professional so you can discuss the contents.

Cancellations and Missed Appointments:

We require 24-hour notice of a cancellation of an appointment. Failure to provide such notice, regardless of the reason, will result in you being billed $50.00 for the first missed appointment and the full fee for subsequent late cancellations or missed sessions.

Insurance will not reimburse you for missed or late-cancelled appointments. _____ (Initial)

Collection Agreement:

In the event that you fail to pay for the services provided by this office in a timely manner, your account may be sent for collection. There will be a collections fee added to the bill equal to 40% of the balance owing at the time the account is placed for collection. You will also be billed for all attorneys' fees and court costs incurred necessary to collect this balance.

By signing below, you are indicating that you are aware of these office policies including the missed appointment fees.

_____ _____

Client or legal representative Date

Yuma Counseling Services

Statement of Informed Consent

Objectives of Counseling:

Often, we become encumbered with thoughts, behaviors, habits, and perceptions that effect our ability to be authentic with ourselves and others. The goal of counseling is to identify with the underlying causes that lead to destructive behaviors and conflicts that we face. This is done through:

1. Healing from the emotional, physical, and spiritual wounds that have been inflicted on you throughout your life.
2. Shedding the layers of personal deception that prevent you from being fully aware of yourself.
3. Owning the parts of your life that you can change and taking the courageous steps to move forward towards desired outcomes.
4. Taking responsibility for your own thoughts, feelings, and perceptions and allowing yourself the ability to change them into healthy, productive thoughts and feelings that will lead you into new and more joyful experiences.

It is important to note that only you can work through your issues. Counseling provides a safe environment in which you can face the issues that hamper your progress, but you remain responsible for the desired outcomes. Your therapist can guide, direct, and inspire, but for the work to be done, you must be responsible to do it. You may be given activities to accomplish between therapy sessions. Whether you do them or not will affect the outcomes you are trying to achieve. There can be no assurances of results and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, intervention, and discussion if these seem unclear to you.

Risks of Therapy:

There are risks in starting therapy. Foremost is facing your fears. This can be tremendously daunting and evoke a range of strong emotions. 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, therapy 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.

Your therapist will not force you to go or do anything for which you are not ready. You may be challenged to complete stretching assignments that take you out of your comfort zone; however, you will never be forced to do anything that you are not willing to do. Please keep your therapist appraised as to what feelings are evoked during and after sessions as well as honestly helping the therapist understand what you feel and don't feel comfortable doing.

Client's Initials indicating you have read and understand the above statements _____

Scope of Practice:
The staff at Yuma Counseling Services are not on-call, nor do they have an emergency staff for after-hours treatment. **If you encounter a life-threatening emergency CALL 911 immediately or Crisis Line: 1-866-495-6735.** If you encounter a non-life-threatening emergency, contact Yuma Counseling Services during normal business hours and discuss the possibility of scheduling an emergency session.
There may be other reasons for which your therapist may find it in your best interest to refer you to more specialized treatment. These would be discussed with you individually, if such occur.

Treatment of Minors:
Yuma Counseling Services will provide counseling to minors (individuals under the age of 18, who are not emancipated). If a parent/legal guardian is bringing the child in for services, the **written consent of both parents** and/or legal guardians is required except as otherwise determined by law. Additional documentation of guardianship might need to be provided in certain circumstances, such as divorce, before treatment can begin. For children younger than 12, the therapist will need to evaluate the situation prior to accepting the child as a client.

Patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is sometimes our 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, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We 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 we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Staff Consultation and Supervision:
Clinical staff of Yuma Counseling Services (including Therapists, Coaches, and Group Facilitators) routinely discusses cases on an as–needed basis to coordinate efforts and enhance treatment. By signing this document, you authorize all clinical staff members at Yuma Counseling Services with whom you work to share information with one another as necessary. Troy L. Love, LCSW is the clinical director of Yuma Counseling Services. Mr. Love is licensed with the Arizona Board of Behavioral Health with the following license number: LCSW-10449. Mr. Love can be reached at 928-276-9535. Any therapists under supervision for state licensure will notify you in writing during their first session with you that they are receiving supervision.

Client's Initials indicating you have read and understand the above statements _____

Confidentiality Limitations:

The therapeutic process often involves your disclosing very personal and highly confidential information to your therapist. Under Arizona law, your confidential information received by reason of our relationship is privileged (See, ARS 32-3283). Only you, the client (or the legal parent or guardian if the client is a minor) has the legal right to waive your privilege. With few exceptions, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires Yuma Counseling Services to obtain a client's authorization prior to disclosing medical information including psychotherapy notes for any reason. (See 45 CFR 164.508(a)(2)).

However, there are some exceptions that may lead to a waiver of the therapist–client privilege and the disclosure of otherwise confidential information. Exceptions include, but are not limited to:

- Suspected abuse or neglect of a child. *This is a state mandated requirement.*
- Sexual activity between a minor and any person age 18 years or older. *This is a state mandated requirement.*
- Suicidal or homicidal ideation with the intention to act on this ideation. *(In the event that you disclose information that you are a danger to yourself or others and you are unwilling to voluntarily admit yourself to inpatient care (hospital or other treatment facility), State Law requires that a psychiatric facility or hospital be contacted to file the appropriate papers for an involuntary admission for treatment. This is to ensure safety for yourself and others and ensure you receive appropriate medical treatment. State law also requires that potential victims and the police be notified if you disclose intentions to hurt another person(s).)*
- A court subpoena ordering the release information as part of a legal involvement.
- Billing insurance companies (for example, filing a claim, responding to insurance audits, or appealing denials, etc). While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written, signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your psychotherapy notes unless we determine that such access is clinically contraindicated.
- We also may have contracts with an attorney, accounting firm, and collection agency. As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

Now or in the future, you may be subject to legal proceedings such as, but not limited to divorce, custody disputes, injuries, lawsuits, etc. In a dispute, a third party may attempt to request your privileged confidential information from Yuma Counseling Services against your best interest. Yuma Counseling Services is not legally allowed to divulge any of your confidential information, unless you waive this privilege in writing. Waiving your privilege may subject you to further harm legally, financially, and emotionally. Therefore, by signing this agreement you **DO NOT AUTHORIZE** the disclosure of your privileged information to any persons including your attorney, or any other individual acting on your behalf, without a court order.

Client's Initials indicating you have read and understand the above statements _____

Your signature below hereby indicates you acknowledge that any future request made to obtain your privileged information by anyone other than you, with the exception of a court of law, will be deemed unauthorized. You further acknowledge that a future waiver from you, in writing, of your privileged information obtained ***without*** prior consultation with your therapist and/or separate legal counsel will be considered the product of coercion, undue influence, or conflict of interest and therefore unauthorized.

Your signature below also indicates that you are hereby notified that if you are the subject of legal proceedings, no employee, therapist or staff member associated with Yuma Counseling Services will testify in court or at any other proceeding, write letters or other statements for legal reasons, nor will your medical records be released to any party requested unless otherwise agreed upon or through court-ordered subpoena.

Consent for Treatment

By signing below, you are stating that:

I accept, understand, and agree to abide by the contents and terms of this agreement. Further, I consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

By signing below, you are indicating that you have had the opportunity to address any questions related to this document with the office staff or your therapist and that you understand the content herein.

Client's Printed Name: _____

Client's Signature: _____ Date: _____
(Or GUARDIAN if client is a minor)

Note: In the case of a minor whose parents have joint legal custody, both parents are required to sign the consent for treatment prior to receiving services at Yuma Counseling Services, PC. Legal documentation verifying sole legal custody may also be used to verify authorization to provide consent. If you have questions, please call us at 928-276-9535.

Client Intake Information

Client Name _____ **Date**_____ **Date of Birth**_____

Religious Affiliation (if any): _____ **Race:** _____

PRESENTING PROBLEMS

What has brought you to counseling at this time?

Mental Health Screening

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at All	**Slight** less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	For office use only
I.	1. Been bothered by stomach aches, headaches, or other aches and pains?	0	1	2	3	4	
	2. Worried about your health or about getting sick?	0	1	2	3	4	
II.	3. Been bothered by not being able to fall asleep or staying asleep, or by waking up too early?	0	1	2	3	4	
III.	4. Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5. Had less fun doing things than you used to?	0	1	2	3	4	
	6. Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7. Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8. Felt angry or lost your temper	0	1	2	3	4	
VII.	9. Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10. Slept less than usual, but still had a lot of energy?	0	1	2	3	4	
VIII.	11. Felt nervous, anxious, or scared?	0	1	2	3	4	
	12. Not being able to stop worrying?	0	1	2	3	4	
	13. Not been able to do things you wanted to do or should have done because they make you feel nervous?	0	1	2	3	4	
IX.	14. Heard voices - when there was no one there -speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15. Had visions when you are completely awake-that is, seeing something or someone that no one else could see?	0	1	2	3	4	
X.	16. Had thoughts that kept coming into your mind that you would do something bad, or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17. Felt the need to check on certain things over and over again, like whether a door was locked, or whether the stove was turned off?	0	1	2	3	4	
	18. Worried a lot about things you touched being dirty or having germs are being poisoned?	0	1	2	3	4	
	19. Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening	0	1	2	3	4	

In the Past Two Weeks, have you…				
XI.	20. Had an alcoholic beverage (beer, wine liquor, etc.).	☐ Yes	☐ No	
	21. Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	
	22. Used drugs like marijuana, cocaine/crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants, or solvents, or methamphetamine (like speed)]?	☐ Yes	☐ No	
	23. Using any of the following medications ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g. pain killers (like Vicodin or OxyContin) stimulants (like Ritalin or Adderall), Sedatives or tranquilizers (like sleeping pills or Valium)	☐ Yes	☐ No	
XII.	24. Thought about killing yourself or committing suicide?	☐ Yes	☐ No	
	25. Have you EVER tried to kill yourself?	☐ Yes	☐ No	

On a scale of 1 – 10, with 10 being the **Best** how would rate how you are feeling in each of the following areas:

Individually (personal Well- Being) _____ **interpersonally (family/ close relationships** _____

Socially (work, school, friends) _____ **Overall sense of well being** _____

EMOTIONAL/PSYCHIATRIC HISTORY

Have you ever seen a therapist for counseling before ☐ No ☐ Yes
If yes, on _____ occasions. Longest treatment by_____
Provider Name
Reason for Treatment: _____ sessions from_____/_____ to _____/_____
Month/Year Month/ Year

Have you ever been admitted to the hospital for a psychiatric, emotional, eating disorder or substance use disorder? ☐ No ☐ Yes **Names and dates of inpatient treatment**:

Has any family member had inpatient treatment for a psychiatric, emotional, or substance use disorder?
☐ No ☐ Yes If yes, who/why (list all):

Have you experienced any of the following trauma/ losses?

Please check all that apply and explain the circumstances, year of the event, and impact that each of these events. (use the back of this page if more space is needed):

✓	EVENT	Details	Rate the effect of these events in your life on a scale 1 – 10, 10 being the worst.
	Death of a Close Friend or Family member		
	Death of a Pet		
	Divorce/Separation		
	Emotionally Abused		
	Loss of a close friendship/ Relocation		
	Loss of Job/ Status		
	Major Illness/Disability/Injury		
	Parental/ Significant Other Conflict		
	Physically Abused		
	Remarriage of a Parent		
	Sexually Abused		
	Sibling Leaving Home		
	Significant Family Conflict		

MEDICAL HISTORY

Allergies: ☐ No Known Allergies or ☐ _____

List any medical conditions for which you are currently experiencing:

List any medications *currently* being taken (give dosage & reason) use other side if necessary:

Medication	Reason	Dosage	Frequency	Physician	Beneficial?

***Prior* medications used for depression, anxiety, or other mental health reasons?**

SUBSTANCE USE HISTORY (check all that apply)

Family Alcohol/Drug Abuse History

☐ Father ☐ Mother ☐ Step-parent/ Live-in ☐ Grandfather ☐ Grandmother

Personal Alcohol/ Drug Use History

☐ No history of abuse

Substances used even one time (Check all that apply)

✓	Substance	Age first used	Age/ or Date last used	Currently using?	How much	How often
	Tobacco					
	Alcohol					
	Cannabis (Marijuana)					
	Amphetamine (Speed, crystal Meth.)					
	Caffeine					
	Cocaine (Crack)					
	Hallucinogens (LSD, Mushrooms)					
	Inhalents (gas, glue, Nitrus Oxide)					
	Opiates (Derion, emerol, Oxycontin, Percocet, Heroine)					
	PCP/Retalar (angel dust)					
	Sedatives (sleeping pills)					
	Club Drugs (Ecstasy, Special K)					
	Other:					

Consequences of substance abuse (check all that apply):

☐ Hangovers ☐ Withdrawal Symptoms ☐ Sleep Disturbance ☐ Binges
☐ Seizures ☐ Medical Conditions ☐ Assaults ☐ Job Loss
☐ Blackouts ☐ Tolerance Changes ☐ Suicidal Impulse ☐ Arrests
☐ Overdose ☐ Loss of control in amount used ☐ Relationship Conflicts ☐ Other:

FAMILY AND RELATIONSHIP HISTORY

	Yes
Are your parents still married to each other?	
If your parents are divorced have they married other people?	
Do you generally feel safe and cared for at home?	
Do you generally feel validated and appreciated?	
Do the rules in your home make sense to you?	
Do you sometimes feel like a lost child, like nobody even seems to notice when you are gone?	

Who lives in your home with you?

How close are you to your family?

Who is your best friend? What do you appreciate the most about your friends?

Describe any involvement in community or recreational activities? What do you like to do for fun? What spiritual activities, if any, do you engage in?

SOCIO-ECONOMIC HISTORY

What School do you go to: _____ What grade are you in? _____

If you have a job, who do you work for? _____

DEVELOPMENTAL HISTORY

Do you have any issues with reading, math, vision, learning, or other learning concerns?

☐ Yes ☐ No

LEGAL HISTORY

Do you have any current or past legal issues? If so, what is the situation? (Arrests, charges, separation/ divorce, etc.)

SEXUAL HISTORY

Sexual Orientation

☐ Heterosexual orientation ☐ Homosexual orientation ☐ Bisexual ☐ Same Sex Attraction ☐ Unsure

Sexual Activity

□ Currently Sexually Active Age of first exposure to pornography: _____ □ History of unsafe sex

Yes	No		
		1.	Have you been sexually abused
		2.	Do you often find yourself preoccupied with sexual thoughts?
		5.	Have you made efforts to quit a type of sexual activity and failed?
		7.	Do you hide some of your sexual behaviors from others?

TREATMENT GOALS

What would you like to be different about you or your situation at the end of treatment?

What goals would you like your therapist to help you in achieving in therapy?