Client Name: ____________________________ **Date of Birth:** ______________
Parent/Legal Guardian:____
Address:
____
____
Phone Number(s):
____

Initial Date of Service: _________________________
Diagnosis:____*(to be filled out by therapist)*
Fee for Service: Yes No Co-Pay: Yes No Amount:_______________
Employed:Yes No Employer name: _______________________________________
Address of Employer:
____

Court Involvement: No Yes Explain:____
____
____
____
Previous Therapist : ____
Primary Care Physician:
_____________________________Address:____
____ Telephone:
_________________________ FAX:___________________________________ Allergies:
____
Specific Health Conditions (we should be aware of)**:**
____
Psychiatrist:
____ Address:
____
____
Telephone: _________________________ Fax: _______________________________
Current Medications *and dosage*:
____
____
Past Medications: ____
____

Insurance Information

Client Information:
Name:______________________________ Date of Birth:_______________________ Responsible party name:__________________________ Relationship to client:_________________
Address:____
Street City State Zip
Phone numbers: _________________

Home: OK to leave message? Y or N_________________________
Work : OK to leave message? Y N___________________________
Cell: OK to leave message? Y N ____________________________

Insurance: Primary
Insurance Company Name: __________________________

Insurance Phone Number: ________________

Insurance ID Number:
____
Insurance Claim
address:____

Name of Policy Holder: __________________________________

Relationship to client:_______________

Address :____
Social Security Number:_______________________
Policy holder Date of Birth: _________________

Co-Pay Amount:________ **Deductible** amount:__________ **Pre-authorization** required: Y N. If yes, Number to call:_________

Adult Intake Questionnaire

Name: ____

Referred by: ____

Why are you seeking therapy at this time?

____
____
____
____
____

CURRENT FAMILY INFORMATION

Partner's Name: _______________________ Yrs. Married/Involved______

Please list children (whether or not they are living with you) and other household members:____
____
____

Other significant information about your/your partner's family that would be helpful to know? Family history of medical and/or mental health problems? Please explain.

____
____
____
____
____

MEDICAL/MENTAL HEALTH HISTORY

Do you currently have any medical problems (include chronic health problems such as asthma, diabetes, etc.)? If so, please list.

____
____

Current medications:____

Have you ever had surgery?

____

Have you had accidents that resulted in serious injury?

____
____
____

Physical Symptoms

_____shortness of breath _____fatigue _____poor appetite _____back pains _____can't sleep
_____panic attacks _____other (specify) ____

Have you ever had outpatient/inpatient mental health treatment? ___yes ___no
Dates of Service: ____
Location : ____
Therapist(s): ____
Psychiatrist(s): ____
Medications prescribed? ___yes ___no Name___________________________
Name___________________________ Name___________________________
Dose_______________ Dose_______________ Dose_______________
_____poor memory _____overweight _____underweight _____chest pains _____always hungry
Are you currently experiencing any of the following problems/symptoms? When did these problems begin? Check all that apply.

___________depressed or ____________irritable mood most of the day, nearly every day
___________diminished pleasure in activities
___________decrease or _____________increase in appetite
___________insomnia (too little sleep) or _____________hypersomnia (too much sleep)
___________fatigue or loss of energy
___________having excessive thoughts of worthlessness or inappropriate guilt
___________difficulty concentrating/thinking
___________suicidal thoughts or thoughts about dying
___________more talkative than usual or pressure to keep talking
___________racing thoughts distractibility
___________agitation, anger outbursts
___________excessive involvement in pleasurable activities that have a potential for painful consequences (buying sprees, sexual activity, etc....)
___________feeling the need to be a perfectionist
___________feeling anxious
___________feeling irritable
___________experiencing lack of self confidence
___________experiencing temper outbursts
___________feeling over active
___________feeling not active enough
___________having upsetting and/or persistent thoughts
___________feeling nervous most of the time
___________experiencing poor self-control
___________unable to make decisions
___________feeling easily confused
___________having too high expectations of self
___________feeling unhappy
___________having too high expectations of others
___________not able to trust others
___________feeling isolated
___________experiencing school problems
___________experiencing work problems

___________experiencing feelings of loss and grief around: _____ death _____ divorce _____ suicide

Have you ever been treated for alcohol or drug dependence? ___Yes ___No
Are you concerned about your use of alcohol or drugs? ___Yes ___No
Has anyone in your family/extended family had drug/alcohol problems or been treated for alcohol/drug dependence? Please explain:

____

____
_ Have you ever been ____sexually abused, ____physically abused, _____emotionally abused?
YES NO
By whom?

____
Is there abuse in your present relationships/family? YES NO
Do you worry about being abusive? YES NO

FAMILY/RELATIONSHIP

Are you experiencing any of the following difficulties? _____ difficulty with partner/spouse _____ staying away from home too much _____ difficulty with children
_____ excessive arguing _____ difficulty with relatives _____ poor communication _____ sexual/intimacy problems _____ lack of understanding other _____ other (specify)____

What are you most concerned about?

____
____
____
____
____

What are some of your goals for therapy?

____
____
____
____
____

Where do you turn for support? Family? Friends? Faith/Spirituality? Work relationships? __________

____
____
____
____

What personal strengths have helped you in the past to deal with difficulties similar to those of concern today?

____
____
____

Therapist / Client Services Agreement

This document contains important information about my professional services and business policies. It also contains your Client Rights and summary information about the Health Insurance Portability and Accountability Act (HIPPA) in the Notice of Privacy Practices. I am required by law to obtain your signature acknowledging that I have provided you with this information at the first session. Please read this document carefully and ask me any questions you may have. When you sign this document, it will represent an agreement between us. This is your informed consent.

Client Rights

1. You have the right to request information about your therapist's qualifications, credentials, experience, specialization and education.
2. You have the right to obtain from another therapist a second opinion regarding the assessment and treatment plan developed to assist with your presenting problem.
3. You have the right to ask for an alternative referral at any time.
4. You have the right to inquire about fees for therapy, billing practices, insurance reimbursement, and other methods of payment.
5. You have the right to terminate therapy when you have reached your goals or believe therapy is no longer necessary.
6. You have the right to refuse the suggested intervention or treatment strategy indicated by your therapist.
7. The frequency and duration of therapy depends on many factors. It is your right to be part of determining jointly with your therapist how long and often you will receive therapy.
8. You have the right to renegotiate therapy as often as needed.
9. You have the right to receive complete and accurate information regarding your diagnosis, treatment, risks and prognosis.
10. While exploring personal issues and making life changes you might experience emotional pain, discomfort and anxiety. You have the right to decide what to talk about and work on in and out of therapy. Nevertheless, your active participation will have the greatest positive effect on the outcome of therapy.
11. You have the right to confidentiality, unless you report to be in danger to yourself or others (Therapists must report to appropriate agencies if you are suicidal or homicidal). Limits also include misconduct of other mental health professionals, suspected abuse of children and vulnerable adults, prenatal exposure to controlled substances, court ordered reports, potential use of a collection agency, and insurance agencies. In these situations, there are limits to confidentiality.
12. If you are a minor, you have the right to request that data about you be kept from your parents. This request must be in writing. The request must include reasons for withholding information from parents.
13. If you are parent of a minor child, you have the right to access information unless a written request has been made by your child to deny access to information.
14. You have a right to see your file.
15. If you are denied coverage by your insurance company, you may either continue treatment on a fee-for-service basis or terminate therapy with a referral.

In addition, HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These new rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an account 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 attached Notice form, and my privacy policies and procedures.

Contacting Me

To schedule an appointment please call (480)235-3124. Since I am often seeing other clients you may reach my voicemail. Please leave me a message with your phone number and a good time to reach you. When I am in the office, I check my messages throughout the day. On days that I am not there, I usually check at least once during the day. The exceptions to this are on weekends, holidays, or when I am sick or on vacation. My voicemail message will be updated periodically as needed. In an emergency, you will be directed to contact your physician, an emergency room or 911.

Limits on Confidentiality

In most situations, I can only release information about you to others if you sign a written Authorization form that meets certain legal requirements. Other situations require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following activities:

- Consultation with other health and mental health professionals during which I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential.
- I also may have contracts with secretarial services, billing services or accounting services. As required by HIPAA, I will have a formal business associate contract with these businesses in which they are required to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.
- Disclosures required by health insurers.

There are other situations in which I am legally obligated to take actions such as in cases of possible child abuse, neglect or self harm. These limits and uses are detailed further in the Notice of Privacy Practices.

I hereby acknowledge that I have received a copy of and read the Therapist/Client Services Agreement form. I further acknowledge that I have been able to ask questions and get clarification with regards to this agreement.

____ __________________
Client/Parent/Legal Guardian **Date**

____ __________________
Client/Parent/Legal Guardian **Date**

CONSENT for TREATMENT & OFFICE POLICIES

(effective 11/01/2010)

I, ______________________________ *authorize therapeutic services for* ____________________________.

(Client/*Parent/Guardian - please circle)* *(Client/Child's full name)*

I. Custody/Guardianship Issues

A. Consent for services can only be authorized by a current legal guardian.
B. If parents are separated, services are provided only with written consent of both parents.
C. For divorced parents, consent may be given by the parent authorized to make medical decisions. If medical decisions are ordered to be made jointly, consent of both parents is required.
D. Copies of legal paperwork (relevant pages) are requested to document the above information.

II. Confidentiality & Release of Information

A. At the family's request, Cynthia Spencer will contact other providers/staff to coordinate care.
B. *No information will be released about your child's therapeutic services without your written permission, except in the following cases:*
   - Insurance companies request dates of service and diagnosis codes. To authorize additional sessions, they request some details about treatment and progress.
   - The law requires Cynthia Spencer to report suspicions or evidence of child abuse, or child's/parent's expressed intention to harm oneself or others.
   - Child records in some circumstances may be subpoenaed. Cynthia Spencer will make every effort to protect confidentiality in these situations.
   - Julie Caldwell LMFT located at 39905 N Gavilan Peak Parkway, Anthem , AZ 85086, shall be named custodian of records to facilitate continued services or provide clients access to their records in the event that therapist is unable to provide this service due to death, disability, close of office or change of office location.

III. **Fees:** ***Payment is expected at the time of service, unless other arrangements have been made.***

A. Accepted forms of payment: Cash or Check.
B. Insurance Charges: If Cynthia Spencer is on your insurance plan, the copay amount applies. Deductibles are paid down in increments of Cynthia Spencer's contracted rates with each plan.
C. Private Pay Charges : A discounted rate will be offered to families who need to pay out of pocket. Intake $140, Family visit $130.00, Individual child visit $120.00. Individualized private pay arrangements can be made at or before the 1st visit. Standard rates are Intake $150.00, Family visit $145.00 and Individual child visit $140.00. For those families experiencing financial hardship, I do hold a few appointment slots at a reduced fee rate.
D. No-show / Late cancel: $65.00 for no-shows and cancellations with less than 24 hrs. notice.
E. Delinquency: After 3 billing statements/contact attempts, unpaid charges are turned over to collections. Policy holder would also be responsible for collection agency's 30% commission.

IIII. Insurance Matters

A. *Check the Mental Health* benefits of your insurance plan.* While Cynthia Spencer provides assistance, ***it is the family's responsibility to verify eligibility, coverage, deductibles & co-pay.***
B. Authorization: Some plans require policy holder to obtain an authorization **#.** If authorization was required but not obtained by 1st visit, policy holder is responsible for session fee(s).
C. Coverage: If insurance coverage details are unclear at intake, full private will be charged. Any overpayment will be reimbursed to the family as soon as coverage is clarified.
D. Denials: Policy holder is responsible for any fees the insurance company declines to reimburse.
E. Primary Insurance: Cynthia Spencer will bill the primary insurance company only. If the policy holder wishes to bill a secondary insurance, a superbill is available upon request.

I have read this form, discussed my questions with Cynthia Spencer, and agree to its terms.

______________________	______	______________________	______
Parent/Guardian signature	*Date*	*Parent/Guardian signature*	*Date*

Cynthia J. Spencer LPC

SERVICES & FEE SCHEDULE

Intake	$ 150.00
Family Session	$ 145.00
(out of pocket discounted rate)	$ 130.00
Individual Session	$ 140.00
(out of pocket discounted rate)	$ 120.00
Telephone Consultations: *with parents, doctors, school staff, parenting coordinators, case workers & other professionals.*	$30.00 / quarter hour
Observation at school or daycare (1 hour visit)	$ 130.00 / hr
Attendance at school staffings / IEP meetings	$ 130.00 / hr
Travel time reimbursement (round trip)	$ 50.00
Court appearance (1 hour minimum)	$ 200/hr
Court report writing	$ 100/per report
Copy fee	$ 50.00/per request
"No Show" or late cancellation (less than 24 hrs notice) *(To cancel a Monday appt., please call prior Friday by 10am)*	$ 65.00
Returned Check Fee	$ 25.00 minimum

*all payments must be paid at time of service

Please sign to acknowledge receipt of this information.

______________________________ ____________________

Client Signature **Date**

Would you like a copy at this time?

*Yes*___ *No*___

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you ___________________________________ and Cynthia Spencer LPC. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here ___________________________________.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and to send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

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

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Privacy Offices by calling 480-235-3124. **See Protecting Your Privacy handout for additional important information about your rights.**

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

1.____ ________________________
Signature of client or representative Date

____ ________________________
Printed name of client or representative Relationship to client

____
Description of representative's authority

2.___________________________________
Witness