Dalena Watson Counseling

90 S. Kyrene Road #4
Chandler, Arizona 85226
P: 480-775-6423 F: 480-775-6425
Dalena@dalenawatson.com
www.dalenawatson.com

New Client Information

Client Information:

Name:_____ SSN:_____
Date of Birth:_____ Age:_____ Gender:_____
Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Work phone:_____ Cell:_____
In case of emergency, please notify:
Name:_____Phone:_____Relationship:_____

Insurance:

Policy holder's name:_____ SSN:_____
Date of Birth:_____
Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Work phone:_____ Cell:_____
Primary insurance:
Company:_____
Authorization #:_____ Number of sessions:_____
Co-pay:_____
Employer:_____ Job title:_____
Relationship to the policy holder:_____
Secondary insurance:
Company:_____
Authorization #:_____ Number of sessions:_____
Co-pay:_____
Employer:_____ Job title:_____
Relationship to the policy holder:_____

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For Healing, Transformation, and Wholeness

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Informed Consent for Counseling

Purpose of Counseling
The purpose of counseling/therapy is to assist you on your path to greater personal growth and healing. The holistic focus of Dalena Watson Counseling is the integration of the mind, body, and spirit.

Treatment
Dalena Watson is a Master-level, Licensed Professional Counselor (LPC) in the state of Arizona. She is also a board-certified music therapist (MT-BC) and her post-master training is as a Fellow of the Association for Music & Imagery (FAMI). Your therapist may use a variety of methods including: cognitive/behavioral, which addresses how your thoughts affect your emotions and how together they influence your behavior; psycho-dynamic, which addresses how your past experiences may be influencing your present emotional health (and the way you see the world); and experiential, which allows direct and symbolic expression of emotions and deeper self insight.

The results you obtain from this counseling will largely depend on your commitment to your own growth process. Therefore, homework may be given to continue your growth process between sessions. During the counseling process, uncomfortable feelings may arise. This is a normal part of counseling and your therapist will assist you in processing and managing these emotions. As you grow and change, people in your life/significant relationships may be affected as others adapt to the new you. This is normal, and should be discussed with your therapist.

With your therapist, you will develop an understanding of the areas you wish to address and the techniques that will best serve you, as well as a treatment plan to guide the direction of your therapy. This plan is reviewed and revised periodically (approximately every 90 days). You have the right to refuse any treatment services or modalities. Your therapist will advise you of any potential consequences of such refusal.

If you are in need of medical attention, you should call 911 or your doctor depending on your need. If you are having a counseling emergency, please call your therapist. If your therapist is not available, please leave a message requesting an emergency call back. If you do not receive a call back within 15 minutes, please call the local crisis line at 1-800-631-1314 or 480-784-1500.

Client Signature Date

Confidentiality
Your sessions are confidential as well as the therapist's notes. Your therapist may use case consultation with other professional therapists in order to serve you better. These therapists will keep any information confidential as well. If you desire specific information to be released to a specific person or agency, you may sign a release of information.

You have the right to request to review your records. You also have the right to request copies of your records. Requests must be made in writing. For copies over 10 pages, you will be charged a fee, 10 cents a page and $10 per hour for copying time. The therapist has a right to deny the request to various items in the record if it is deemed psychologically harmful to you (ie: raw testing data, personality assessments, etc).

The therapist may be legally bound to disclose information if you disclose committing a crime, aiding another in criminal activity, are involved in abuse/neglect/exploitation against a minor or elder, are a danger to yourself or others, or by court-order.

Limitations of Technology
While technology (ie: computers, Internet, cell phone, email, faxes) are used in the normal course of business at Dalena Watson Counseling, there are limitations to the confidentiality of such technology. Every reasonable effort is made to secure your information.

Your therapist will print and file in your records any email correspondence that you send. However, emails will not be electronically archived.

Notice of Privacy Practices and Client's Rights
Please sign below that you have read and received copies of the Privacy Practices and Client's Rights documents.

Client Signature Date

Payment/Fees
Payment will be arranged with your therapist, and is due at the time of services. In telephone counseling, payment must be pre-paid. Cancellation fees of $50 per session apply if you do not notify the therapist 24 hours before your scheduled session.

If you would like to utilize your insurance plan, Dalena Watson will submit billing to your insurance (through her contracted billing company) if Dalena Watson is in network with your insurance company.

If she is out of network with your plan, please self-pay and then file for reimbursement. It is advised that you investigate your insurance coverage prior to beginning treatment. You may need to inquire as to diagnoses covered, number of sessions, types of mental health services covered, and out of network provider coverage. Your therapist can provide you with a Superbill including the documentation necessary for insurance purposes.

I have read and received a copy of the fee schedule document.

Client Signature Date

Referrals for Additional Services
At times, your therapist may give you suggestions and/or referrals for additional services. It is your responsibility to investigate these options and whether or not you enter into a professional arrangement for additional services. If you have a negative experience with a referral, please inform your therapist.

Telephone Counseling
This service is available to established adult clients only. Payment must be arranged in advance and is not covered by insurance. You will benefit more from this service when you arrange a comfortable environment for yourself, free from distractions or interruptions. Telephone counseling may not be appropriate for all. Please be advised that telephone counseling may not be entirely confidential if one or both parties are using a cell phone.

If during a telephone session, there is equipment failure, please attempt to reconnect immediately. If this is not possible, the session will be billed for time completed.

Some disadvantages may include: lack of visual cues (body language, facial expression for both the counselor and client), possible difficulty in assessing emergency or suicidal situations.

Client Signature Date

Termination of Services

You or your therapist may choose to terminate the therapeutic relationship at any time. Optimally, this decision is made jointly during the session, and after you have met the treatment goals. If this decision is made outside of the session, whoever makes this decision must contact the other party in writing (email) or by phone. The counselor may also choose to terminate services if you are not progressing, you need other services the counselor cannot provide, if you or another person with whom you have a relationship are deemed to be a danger to (likely to harm) the therapist, or you do not pay your fees. Your therapist will recommend other providers when necessary.

Should your therapist be unable to provide therapeutic services, a plan has been developed to continue your counseling with a qualified professional.

Scheduling Sessions

Call 602-686-3723 or email dalena@dalenawatson.com to schedule appointments. By making arrangements to use the therapeutic services, you are agreeing to all of the conditions stated in this informed consent. If you have questions regarding this information, please ask.

Client Signature Date

Therapist Signature Date

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HIPAA NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003. Dalena Watson Counseling only releases information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes the policies related to the use and disclosure of clients' healthcare information.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Your healthcare information may be used and disclosed to appropriate sources for the following reasons:

Treatment:
- Provide, manage or coordinate care
- Consultants
- Referral sources

Payment:
- Verify insurance and coverage
- Process claims and collect fees

Healthcare operations:
- Review of treatment procedures
- Review of business activities
- Certification
- Staff training
- Compliance and licensing activities

Other uses and disclosures without your consent:
- Mandated reporting
- Emergencies
- Criminal damage
- Appointment scheduling
- Treatment alternatives
- As required by law

CLIENT RIGHTS: As a client of mental/behavioral health services you have the following rights (more detailed information of most of these categories is provided in your consent to treatment):

Right to request where we contact you:

- Home _____ yes no
- Work _____ yes no
- Cell phone _____ yes no
- Email _____ yes no
- If not, how may we contact you _____

Right to release your medical records:

- Written authorization to release records to others
- Right to revoke release in writing
- Revocation is not valid to the extent that the counselor has acted in reliance on such previous authorization

Right to inspect and copy your medical billing records:

- Right to inspect and receive a copy of your records
- Counselor may deny this request
- Charges for copying, mailing, etc. apply

Right to add information or amend your medical records:

- May request to amend your record
- Counselor has 30 days to decide
- Counselor may deny the request
- If denied, you have the right to file a disagreement statement
- Disagreement and the counselor's response will be filed in the record
- Amendment request must be in writing

Right to Accounting of disclosures:

- For a six year period beginning with date the counselor came in to compliance (no later than 4/14/03)
- Exceptions:
  - Disclosure for treatment, payment or healthcare operations
  - Disclosures pursuant to a signed release
  - Disclosure made to client
  - Disclosures for national security or law enforcement

Right to request restrictions on uses and disclosures of your healthcare information:

- Must be in writing
- Counselor is not obligated to agree

Right to complain:

- Please contact the counselor first in person or in writing
- If not satisfied, you have the right to complain to the U.S. Dept. of Health and Human Services
- To be free from retaliation

Right to receive changes in policy:

- You may request any future changes to these policies
- Submit your request to privacy officer

_____ _____

Client's signature Date

_____ _____

Therapist's signature Date

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Service Agreements

Please initial each statement.

_____ I understand the information about insurance reimbursement, and authorize the release of my pertinent health information to my insurer, and the direct payment of my insurance benefits to Dalena Watson, LPC.

_____ I realize that I am responsible for paying all non-covered services, deductibles, copays, coinsurances, and fees for documentation or cancellation penalties.

_____ I understand that Dalena Watson, PLLC is a sole proprietor, and her practice is independent from the other clinicians who share the office in which I receive treatment.

Fees For Service

Service Code	Service	Fee
90791	Initial intake appointment	$180
90834	30- 45 min. therapy session	$120
90837	51-60 min. therapy session	$150
90846	Family session w/out patient	$150
90847	Family session w/ patient	$150
--	No show or late cancellation	$50
--	Returned check	$35
--	Letters/paperwork	$30/15 min.
--	Review of outside materials	$30/15 min.
--	Court time, prep, travel	$150/hour

Credit Card on File: ☐ VISA ☐ Mastercard ☐ Discover ☐ Amex ☐ Health Savings

_____
Card number

_____
Exp. Date CVV Code Zip Code

_____
Name as it appears on card

I understand and agree to comply with the policies of Dalena M. Watson, PLLC. I am aware I can obtain copies of all paperwork I sign.

I *authorize the charge of my credit card* for all services, documentation and cancellation penalties, etc. incurred.

_____ _____
Signature Date

_____ _____
Printed name Date of birth

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **INSURANCE**: I request that payment of authorized insurance benefits be made on my behalf to Dalena Watson for services furnished to me by Dalena Watson. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Dalena Watson accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the insurance carrier.

2. **RELEASE OF INFORMATION**: Dalena Watson may disclose all or any part of my medical record and/or financial ledger, to any person or corporation which is or may be liable or under contract to Dalena Watson for reimbursement for services rendered, and any health care provider for continued patient care.

3. **OTHER INSURANCE**: I understand that Dalena Watson maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Dalena Watson has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Dalena Watson if I belong to a plan that does not appear on the above-mentioned list.

4. **NON-COVERED SERVICES**: I understand that Dalena Watson contracts with health care service plans. (i.e., HMO's, PPO's) Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plan's not to be covered.

   Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Dalena Watson to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT**: I agree that in return for the services provided to the patient by Dalena Watson, I will pay my account at the time of service is rendered or will make financial arrangements satisfactory to Dalena Watson for payment. If an account is sent to collections, I agree to pay collection expenses and/or reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Dalena Watson. If my insurance company or health plan designs co-payments and/or deductibles, I agree to pay them to Dalena Watson. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of the bill. I also agree that if I have to miss a scheduled appointment without giving at least 24 hours notice. I can be charged a $50.00 cancellation fee.

6. **PRIVACY PLAN**: I agree that I have been given the opportunity to read and receive a copy of the Dalena Watson agreement. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____

Beneficiary or Guardian Name (print)

_____ _____

Beneficiary or Guardian Signature** Date

** If an authorization is signed by an individual's personal representative, the representative's authority is based on:

_____ (e.g., state law, court order, etc.)

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ADULT INTAKE INFORMATION

Welcome. Please fill out all information as completely as possible. Information given is strictly confidential and will help in providing the best possible service. Feel free to ask questions, if needed. Your counselor will discuss the information with you after reviewing the form.

Name: _____ Date Today: _____

Email Address: _____
(May we email? Yes No)

Occupation: _____
Employer: _____ How Long: _____
Work Phone: _____ (May call: Yes No Leave Message: Yes No)

Gender: □ Male □ Female □ MTF □ FTM Date of Birth: _____/_____/_____ Age: _____
Primary Language: _____ Ethnicity: _____
Religious Affiliation: _____

(We respect individuals of any age, gender, ethnicity, race, religion and sexual preference. Gathering the above information can help ensure that your counselor is respectful of your family's background and beliefs.)

Current living arrangements:

Family of origin _____	Relatives _____	Single _____
Married _____	Roommate(s) _____	Single parent _____
Married w/ children _____	Significant other _____	Domestic partner _____
Domestic partner w/children ____	Widow(er) _____	Other _____

Full Name Relationship Phone #

* GENERAL INFORMATION *

Briefly, please state what issue(s) bring you to seek counseling services.

_____
_____
_____
_____

Long term relationships/marriages:

_____
_____
_____

Pregnancies, children:

_____
_____
_____

Are you presently receiving counseling or mental health services elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor)

Family members receiving services at this agency: Yes No (Names/Dates of service) _____
_____

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? Yes No

Previous Mental Health Professional/Agency and reason: _____
_____
_____
_____

Have you been hospitalized or confined for mental health concerns? Yes No
If yes: When _____ Where _____

Are you seeking services because you are a victim of a crime? Yes No
If yes, please provide a brief explanation _____
_____
_____
Did it result in legal action? Yes No If yes, please explain _____
_____
_____
If yes, is involvement with the legal or judicial system currently ongoing? Yes No
If yes, please list names of any lawyers, detectives, & other persons involved _____
_____
_____
(If involvement with the legal/justice system is current, please provide your counselor with the status of any current court orders involving counseling services)

Person responsible for financial arrangements with the agency: _____

Last year of education completed:

8th grade or below _____	Trade School _____	Master's Degree _____
High School ____	Some College _____	Ph.D. Degree _____
GED _____	College Graduate _____	

History of learning, emotional, or behavioral problems: Yes No
(If yes, please explain) _____

Spiritual/religious upbringing and current beliefs:_____
_____

History of alcohol/drug/substance abuse: Yes No
(if yes, please explain) _____

History of domestic violence: Yes No
(if yes, please explain) _____

History of violence in family of origin: Yes No
(if yes, please explain) _____

History of criminal activity: Yes No
(if yes, please explain) _____

Are you currently on probation? Yes No If yes, Probation Officer: _____

*** HEALTH ***

Primary Care Physician: _____
Name Phone

_____
Address

Date of LAST complete physical _____
Physical Disability: Yes No (If yes, explain) _____
Chronic Illness: Yes No (If yes, explain) _____
Terminal Illness: Yes No (If yes, explain) _____

Check the following items for a diagnosis or medication that you <u>are now</u> receiving <u>or have</u> received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of Medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Bipolar	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If you have been diagnosed, who gave the diagnosis?
Counselor/Psychologist _____ Family Physician _____ Psychiatrist _____
School Psychologist _____ Other _____
Name: _____ Phone #: _____

What other medication are you currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*** CURRENT CONCERNS ***

Indicate severity of up to 10 items that currently apply to you. (l-mild; 2-moderate; 3-severe) Circle the item that you see as the most significant issue)

_____ Abuse (physical, emotional, sexual)
_____ Adjustment to life changes (job loss, divorcing, getting married or divorced, aging, etc.)
_____ Career Decisions
_____ Disturbing memories (past abuse, neglect or other traumatic experience)
_____ Drug or alcohol use (both legal and illegal drugs)
_____ Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
_____ Family or Stepfamily relationship problems
_____ Feeling angry or irritable
_____ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
_____ Feeling guilty or shameful
_____ Feeling sadness or depression NOT related to grief
_____ Feeling sadness or depression related to grief
_____ Gender identity concern
_____ Health concerns (physical complaints and/or medical problems, chronic illness)
_____ Non-family relationship problems (friends, significant other, etc.)
_____ Parent-Child relationship (discipline, single parent. etc.)
_____ Personal Growth
_____ Religious or Spiritual concerns
_____ Sexual concerns
_____ Sexual identity concern
_____ Sleep problems (nightmares, sleeping too much or too little, etc.)
_____ Suicidal Ideation (thoughts of death, wanting to die)
_____ Unusual experiences (loss of periods of time, sensing unreal things, etc.)
_____ Other (explain)

** Remember to circle the most significant issue.*

When did you first become concerned about this issue? _____

How have you attempted before now to deal with this issue? _____
_____

Other treatment you have received to address any of the concerns indicated above:

None _____	Individual Counseling _____	Family Counseling _____
Group Counseling _____	Hospitalization _____	Other _____
Spiritual Counseling _____	Healer _____	

*** HISTORICAL EXPERIENCES ***

(For each of the following items that apply, write in your approximate age at the time it occurred):

Raised by:

Natural parents _____	Single natural parent _____	Natural & step-parent _____
Adoptive parent(s) _____	Relatives _____	Foster parents _____
Grandparents _____	Institution _____	Other _____

Please describe your father (or male figure who raised you)._____
_____
_____

Please describe your mother (or female figure who raised you)._____
_____
_____

Please list your siblings, ages, and your relationship with them as a child and as an adult._____
_____
_____
_____
_____

Stressors in the Family:

Chronic illness of family member _____ Death of significant person _____
Domestic Violence _____ Parents arguing frequently _____
Family member absent (explain)_ _____
Family member's disability/major accident/illness _____
Family member emotional/mental health problems (explain)_____
_____
Family member suicide (explain) _____
Financial problems_____ Parents divorced _____
Moved a lot _____ Other _____

Have you ever been abused (check all that apply):
Physically ___ Emotionally _____ Sexually _____ Spiritually_____
Have you ever been neglected (check all that apply): Physically _____ Emotionally _____

History of concerns including recent changes in any of the following: (check all that apply)

Appetite change _____	Hearing voices _____	Suicidal thoughts _____
Emotional problems _____	Loss of energy or fatigue _____	Suicide attempts _____
Gained weight _____	Lost weight _____	Paranoia _____
Accident-prone _____	Aggressive behavior (explain) _____	
Alcohol/drug use _____	Attention problems _____	Frequent arguments _____
Hyperactive _____	Impulsive _____	Loner _____
Taken advantage of _____	Temper outbursts _____	Irritable _____
Obsessive worrying _____	Easily startled _____	Phobias _____
Keyed up, on edge _____	Asthma _____	Disability _____
Nervous stomach _____	Reading minds _____	Dizziness _____
Neurological problems_____	Bone/joint/muscle _____	Headache (kind) _____
PMS _____	Chest pain _____	Heart palpitations _____
Serious overeating _____	Undereating _____	Chronic illness _____
Hospitalization _____	Shortness of breath without exertion ___	
Major accident _____	Sleep problem _____	Diarrhea _____

Developmental delay(s) _____ Major illness _____ Surgeries _____
Death of a pet ____ Death of a significant person ____ Natural disaster ____
Incarcerated family member ____ Medical treatment ____ Sexual assault ____
Witnessed violence or death ____ Victim of trauma (unusual, terrifying experience) _____
Other _____

Support System (such as church, friends, relatives, school)
Hardly any support 1 2 3 4 5 Considerable support

Please list who is in your support system
_____
_____
_____

What are your interests?
_____
_____
_____
_____

How were you referred to the agency? _____

May we thank your referral source? □ Yes □ No
If yes, contact information:

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Release of Information

Client's name _____ D.O.B. _____

For the purposes of providing comprehensive care, the following information is to be released to or exchanged with:

Name _____

Address _____

Phone _____ Fax _____

Information to be released or exchanged:

o Progress Notes
o Discharge Summary
o Treatment plans
o Testing/Assessment results
o Verbal and written consultation/communication
o Other _____

I consent also for information to be released from _____ to Dalena Watson.

To be effective from _____ through _____(not to exceed 1 year).

I, _____ authorize this release of information and understand its purpose. I understand that I may revoke this release in writing at any time.

_____ _____
Client's signature Date

_____ _____
Therapist's signature Date