

Deer Valley Counseling

"Skills for Better Living"

Client Information Sheet – Child or Adolescent – Insurance

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile Phone: _____

Employer: _____ Work Phone: _____

Preferred Method for Courtesy Appointment Reminders to Parent:

- Call to Home Phone Call to Mobile Phone Text Message to Mobile Phone Do Not Remind Me
- Email: To maintain confidentiality, send an email to dvc@deerval.com to confirm your email address

Note: You are responsible for appointments you schedule whether you receive a courtesy reminder or not.

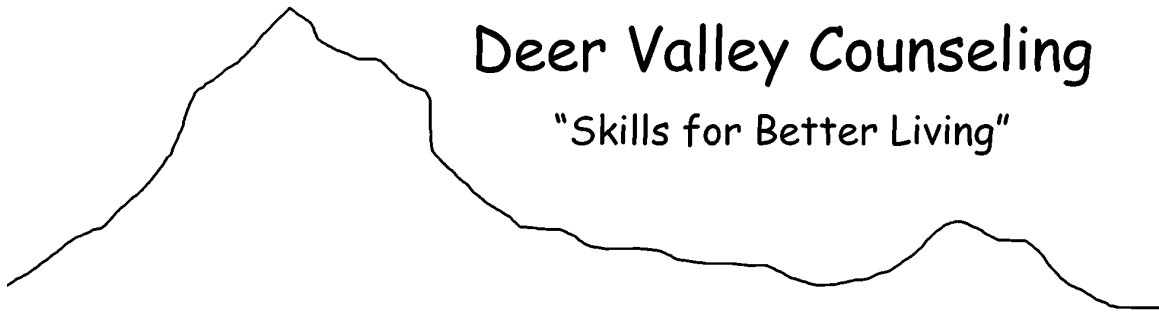
Emergency Contact: _____ Phone: _____

Referral Source:

- Searched Provider Directory on Insurance Company Website
- General Internet Search. Search Terms: _____
 - Bing Yahoo Google Psychology Today SuperPages.com DexKnows Other
 - Find-a-Therapist.com GoodTherapy.org Counsel-Search.com Family-Marriage-Counseling.com
- Phone Book: DEX Verizon Other: _____
- Another Client: _____
- Friend, relative, or acquaintance: _____
- Doctor or other professional: _____
- Other: _____

Therapist's Signature

Date



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Payment Policy

If you need to cancel or reschedule an appointment please call **24 hours** in advance or your credit card on file will be charged at the full rate or you will be billed at the full rate.

You are responsible for attending each appointment you schedule unless you explicitly cancel or reschedule at least 24 hours in advance of the appointment. If you are sick call 24 hours in advance to cancel. If you feel better on the day of your appointment you can always call to reschedule. Appointments made less than 24 hours in advance cannot be canceled or rescheduled.

If you are late you will be charged the full rate for your appointment. If you have insurance you will be personally responsible for the entire cost since insurance will not pay for partial appointments.

Payment is due at the time of service. There will be a \$20.00 charge for each returned check. There will be a \$40 charge for each denied or chargeback credit card or debit card transaction.

Balances will be billed to the last address you give us. There is a \$10 fee for every bill sent out.

Accounts more than 60 days late may also be subject to collection and legal fees without notice. Overpayments will be refunded upon request. Refunds for overpayments will be mailed to the last address you give us. There is no refund for services, fees or missed appointments.

Telephone consultations with your counselor are billed at your counselor's standard rate, in fifteen minute increments, rounded up to the nearest fifteen minutes.

If you check out a book and do not return it within 30 days, you will be charged a \$20 book replacement fee.

You have the right to be informed of all fees that you are required to pay and to be informed of Deer Valley Counseling's refund and collection policies and procedures.

(Consent to Treat on Reverse)

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Deer Valley Counseling, 2301 W Dunlap Ave, Suite 206, Phoenix AZ 85021

Office: 602.750.8051, Fax: 602.674.5701, www.deerval.com

Consent to Treat

The purpose of this form is to obtain informed consent before Deer Valley Counseling provides services to you or your child. If we are providing services to your child, then the approach, risks and benefits discussed in the following paragraphs should be taken as applying to your child. If you are going to participate in the treatment of your child, then you will need to sign a consent to treat for both yourself and your child.

You are consenting to individual, couple's, family and/or group treatment. You have the right to refuse any recommended treatment, withdraw your consent to treat at any time in writing, and to be advised of the consequences of refusing treatment or withdrawing your consent to treat. This consent to treat lasts until the last date on which you receive services. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan.

Deer Valley Counseling utilizes various forms of psychotherapy such as cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), eye movement desensitization and reprocessing (EMDR) and relapse prevention (RP). The purpose of treatment is to help you achieve your goals in life. Goals in treatment typically relate to changing how you feel or behave. The counselor will discuss your situation with you to help you determine what it is you want to accomplish in treatment. Based on your treatment goals, over time the counselor will help you identify thought patterns which may be preventing you from achieving your goals. The counselor will help you challenge old patterns of thinking and develop new patterns of thinking. The counselor may suggest assignments for you to do.

It is not possible to predict how long treatment will take. Some problems can be addressed in just one or two sessions. Others may take years.

Although psychotherapy has been shown to be effective in many cases, success cannot be guaranteed. Psychotherapy is not effortless and often requires hard work to be effective. Psychotherapy does not mean that you will never have any problems ever again.

It is our expectation and hope that you will achieve your goals and become a happier, more effective individual, but at times in treatment your problems may worsen. You may feel worse and behave worse. Relationships with others may become more difficult. If any of this happens be sure to discuss this with the counselor.

If we are providing telephone services to you, there are additional risks. There is a risk that the telephone conversation will be intercepted. Rapport may be more difficult to establish and maintain. It may be more difficult for the therapist to detect when you are in crisis. There is a greater chance of miscommunication. Be sure to discuss any concerns with your the counselor.

If you are receiving counseling from an intern, you should be aware that interns have not completed their training and are not licensed. There is greater risk of an intern not providing the most appropriate treatment. If you have any concerns or questions please do not hesitate to contact the clinical director, Sandra Nettles, at 602.750.8051.

Although research has shown psychotherapy to be the most effective treatment modality for many problems, you may instead seek medication, attend self-help groups, utilize pastoral counseling or read self-help books.

The counselor will discuss treatment goals, procedures, benefits, limitations, and risks with you during your first session and from time-to-time during treatment. Be sure to ask questions and express concerns whenever they arise.

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Notice of Privacy Practices

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

Information that identifies you and your physical or mental health and related health care services is referred to as Protected Health Information (PHI).

Our Duties Regarding Your PHI

We are required by law to maintain the privacy of your 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 (NPP). We reserve the right to change the terms of our NPP at any time. Any new NPP will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised NPP by posting a copy on our website.

How We May Use & Disclose Your PHI

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 treatment. For example, if you attend both group and individual counseling, the therapist facilitating the group may discuss your PHI with the therapist you see for individual counseling.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. Examples of payment-related activities include: making a determination of eligibility or coverage for

insurance benefits, processing claims, billing a third party for services, or charging the credit card of someone paying for your services.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities. Examples include quality assessment, employee review, licensing, analyzing marketing effectiveness, or arranging billing or typing services. We may use your PHI for internal training or teaching purposes. We may use your PHI to suggest to you other medical and non-medical services. We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Without Authorization. We must disclose your PHI without your authorization under certain circumstances -

- **Required by Law.** We must disclose your PHI when required by law, such as the mandatory reporting of child abuse or neglect, mandatory reporting of unprofessional conduct of another behavioral health care licensee, or mandatory audits or investigations by government agencies such as the Arizona Board of Behavioral Health Examiners, the Arizona Department of Health or the Secretary of the Department of Health and Human Services.



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• **Required by Court Order.** We must disclose your PHI when ordered to by a court.

• **To Prevent Harm.** We must disclose your PHI when necessary to prevent or lessen a serious and imminent threat to the health or safety of you, another person or the public.

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

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI. To exercise any of these rights, please submit your request in writing to our Privacy Officer at James Nettles, Privacy Officer, Deer Valley Counseling, 2301 W Dunlap Ave, Suite 206, Phoenix AZ 85021.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI. We are not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that we communicate with you in alternative ways or at alternative locations.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and

copy your PHI or your minor child's PHI. Note that in couple's or family therapy, for records that pertain to more than one person, every legally competent adult whose PHI or whose minor child's PHI is contained in that record must agree in writing before that record can be released to any one of the adults. We may charge a reasonable, cost-based fee for copies.

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. We are not required to agree to the amendment.

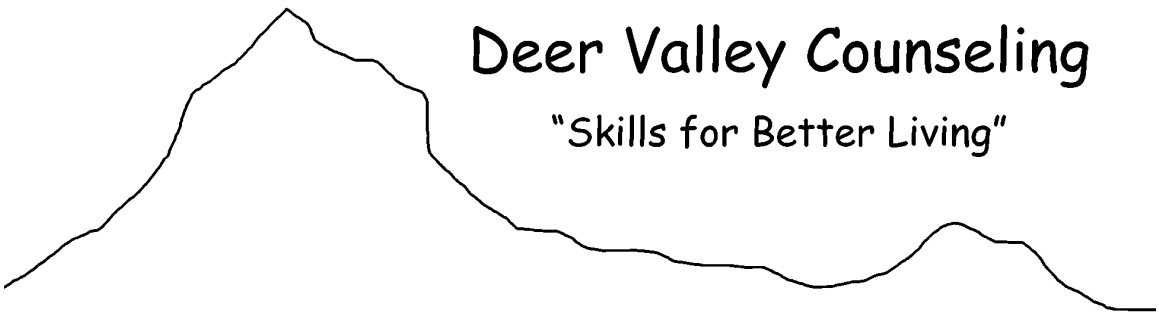
Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to a Copy of this Notice. You have the right to a paper 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 James Nettles, Privacy Officer, Deer Valley Counseling, 2301 W Dunlap Ave, Suite 206, Phoenix AZ 85021 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

The effective date of this Notice is October 31, 2009.



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Receipts, Acknowledgments, Permissions & Consents

Child's Name: _____ **DOB:** _____

I hereby acknowledge that I have received and have been given an opportunity to read copies of Deer Valley Counseling's Payment Policy, Consent to Treat and Notice of Privacy Practices. I understand that if I have any questions regarding privacy rights, I can contact James Nettles, Privacy Officer, Deer Valley Counseling, 2301 W Dunlap Ave, Suite 206, Phoenix, AZ 85021.

I authorize Deer Valley Counseling to bill my insurance company and for my insurance company to pay Deer Valley Counseling directly.

I understand that insurance companies do not reimburse for missed appointments or appointments where my child arrives late and that I will be financially responsible for missed appointments or late arrivals.

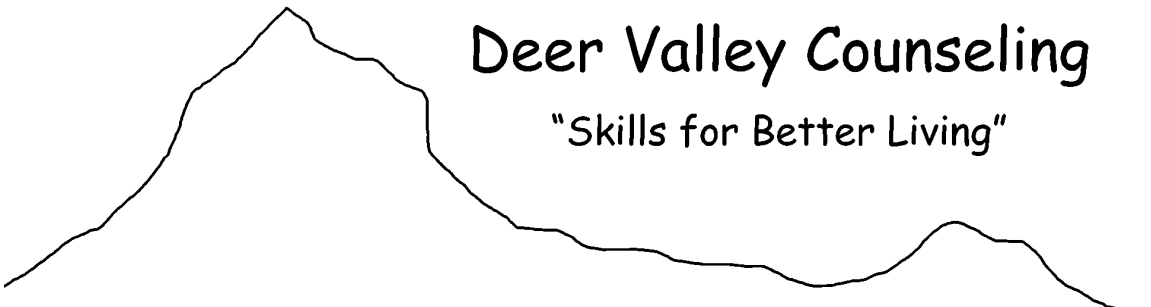
I hereby give my permission for Deer Valley Counseling to charge my credit card on file the full rate for any missed appointments not canceled or rescheduled 24 hours in advance, for late arrivals and for any copay, coinsurance, deductible or other fees not paid at time of service.

I hereby give my permission and consent for my child to participate in the treatment provided by Deer Valley Counseling.

Parent/Guardian Name

Parent/Guardian Signature **Date**

Therapist's Signature **Date**



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Client History – Child or Adolescent

Name: _____

Employer/School: _____ Grade: _____

Occupation/Studying: _____

Parent's Marital Status: Married Divorced Separated Never Married Deceased

Number of Sisters: ____ Number of Brothers: ____ Birth Order: Eldest Middle Youngest Only

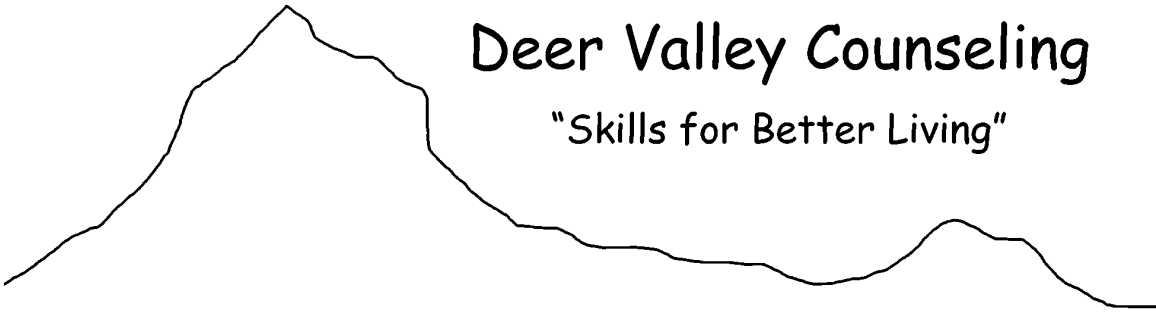
With Whom Does Youth Live: _____

	First Name	Frequency of Contact	Quality of Relationship
Parent/Guardian			
Parent/Guardian			
Step Parent			
Grandparents			
Aunts/Uncles			
Brothers			
Sisters			
Friends			

- Family History of:
- Depression
 - Suicide Attempts
 - Anxiety
 - Chronic Illness
 - Mental Illness
 - Eating Disorders
 - Alcoholism
 - Violence
 - Sexual Abuse
 - Emotional Abuse
 - Drug Addiction

Please explain any items checked above: _____

Therapist's Signature: _____ Date: _____



Deer Valley Counseling

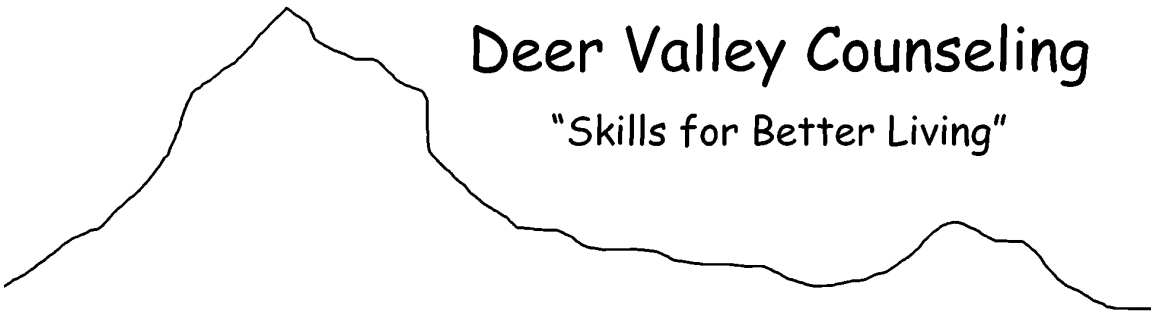
"Skills for Better Living"

Name: _____

How often does the youth experience the following thoughts or behaviors?

	Never	Rarely	Sometimes	Frequently	Please Explain
Depression					
Restless or easily annoyed					
Uncontrolled crying					
Suicidal thoughts or attempts					
Fatigue or difficulty sleeping					
Difficulty concentrating					
Lack of interest in old activities					
Harms self					
Anxiety					
Panic attacks or nightmares					
Specific fears					
Startles easily					
Low self-esteem or shyness					
Peer problems					
Learning difficulties					
Bed-wetting/day-wetting					
Inappropriate sexual behavior					
Verbally/physically aggressive					
Tantrums or defiance					
Running away					
Conduct problems/lying/stealing					
Alcohol or drug use					
Persistent thoughts/behaviors					
Excessive energy or activity					
Hears voices					
Excessive weight gain or loss					
Questions about gender					
Questions about orientation					

Therapist's Signature: _____ Date: _____



Deer Valley Counseling

"Skills for Better Living"

Name: _____

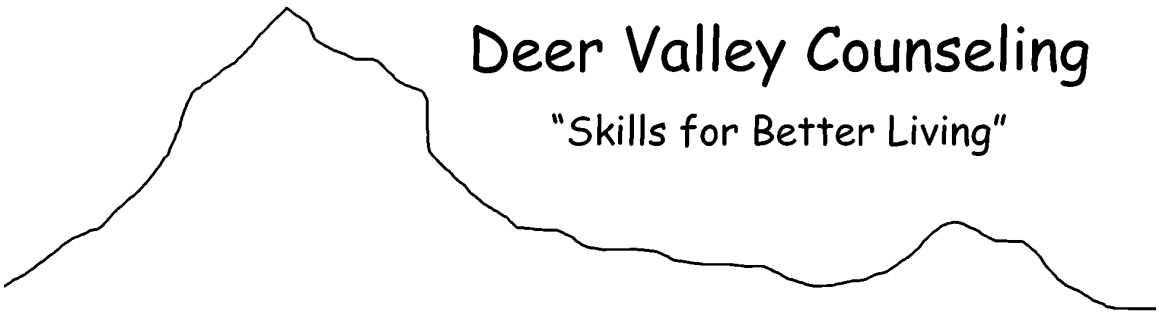
Has the youth experienced any of the following?

- Neglect: _____
- Physical, sexual or emotional abuse: _____
- Trauma or assault: _____
- Witness trauma, assault or domestic violence: _____
- Death of a someone important: _____
- Physical illness (self or family): _____
- Mental illness (self or family): _____
- Legal issues (self or family): _____
- Alcohol or drug abuse (self or family): _____
- Other family problems: _____
- School problems: _____
- Bullying: _____
- Head trauma or injury: _____

Previous counseling, inpatient mental health treatment or drug/alcohol treatment –

Who or Where	Problem Addressed	How Many Sessions	Result

Therapist's Signature: _____ Date: _____



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Name: _____

Primary Care Physician: _____ Phone: _____

Address: _____

During Pregnancy Did Mother Smoke: No Yes How Much: _____

During Pregnancy Did Mother Drink: No Yes How Much: _____

During Pregnancy Did Mother Use Illegal Drugs: No Yes Which: _____

During Pregnancy Was Mother Under Stress: No Yes _____

Age of Mother at Birth: _____ Age of Father at Birth: _____

Birth Complications: _____

Reached Developmental Milestones: Early On Time Late

Explain: _____

At What Age Did Child Talk: _____ Crawl: _____ Walk: _____

Behavioral Concerns During Infancy and Early Childhood: _____

Major, Chronic or Current Illnesses, Injuries, Loss of Consciousness, Other Medical Conditions: _____

Operations: _____

Immunizations: _____

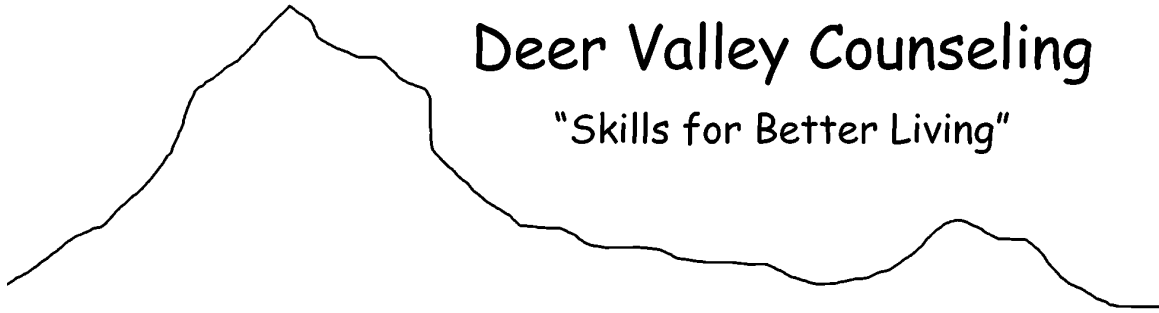
Does youth smoke? Yes No If so, how much _____

Does youth consume alcohol? Yes No If so, how much _____

Does youth take street drugs or misuse prescription drugs? Yes No

If so, please list: _____

Therapist's Signature: _____ Date: _____



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Name: _____

	First Name	Current Age or Age at Death	Illness/Cause of Death	Occupation
Mother				
Father				
Grandparents				
Aunts/Uncles				

Any recent changes in – Sleep Nightmares Exercise Sexual Desire Appetite Weight

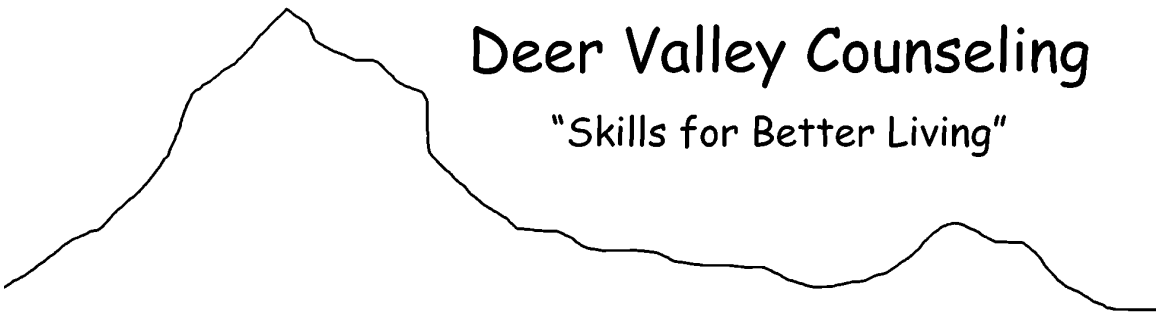
Overall health – Poor Fair Good Excellent

Medication Including Over-the-Counter	Dose	How Often	Effectiveness	Prescribing Physician

Medication Allergies & Adverse Reactions: _____

Other Allergies: _____

Therapist's Signature: _____ Date: _____



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Treatment Plan, Original or Revised

Name: _____

Client Statement of Problems: _____

Goal 1: _____

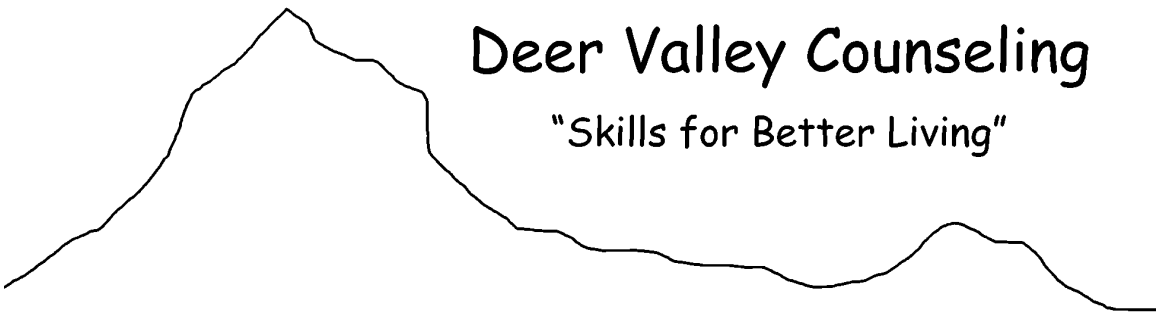
Goal 2: _____

Goal 3: _____

Therapist's Signature

Date

Attach additional sheets if necessary.



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Name: _____

The therapist will fill out this portion.

Treatment Method: _____

Treatment Method: _____

Treatment Method: _____

Treatment Method: _____

Aftercare Requirements: _____

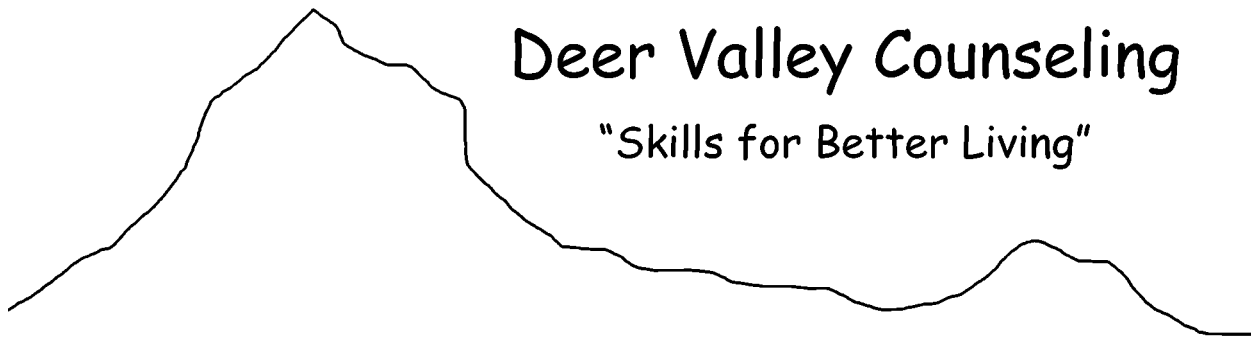
I have met with staff and participated in the planning process of this treatment plan. It has been explained to me in language that I understand. I understand the risks and benefits of these services. I agree and consent to receive services as outlined in this plan. This plan will be reviewed one year from the date it is signed or sooner if clinically indicated.

Client's Signature Date

Parent or Guardian's Signature Date

Therapist's Signature Date

Attach additional sheets if necessary.



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Authorization for Release of Confidential Information To Primary Care Physician

I, _____ Date of Birth of Client: _____
(Client's Name or Person Authorized to Sign for Client)

hereby authorize Deer Valley Counseling to release information to the client's Primary Care Physician (PCP) and for the client's PCP to release information to Deer Valley Counseling.

(PCP Name) (Telephone Number)

(Address) (Fax)

I understand that the purpose of these disclosures is to coordinate treatment.

I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be redisclosed by the recipient and at that time would no longer be protected by the originator. I understand that Deer Valley Counseling may not condition services upon my signing this authorization unless the services are provided to me for the purpose of creating health information for a third party. This authorization for release of information will expire on

_____ (if left blank, one year from the date it was signed).

Printed name of Client Signature of Client Date Signed

Person Authorized to Sign for Client Signature of Person Authorized to Sign Date Signed

Reason person may sign for client: Parent Guardian Other: _____

Client declined to authorize release of confidential information to PCP.