

# Deer Valley Counseling

"Skills for Better Living"

## Client Information Sheet – Child or Adolescent

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

### Preferred Method for Courtesy Appointment Reminders:

- Call to Home Phone     Call to Mobile Phone     Text Message to Mobile Phone     Do Not Remind Me  
 Email: \_\_\_\_\_

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

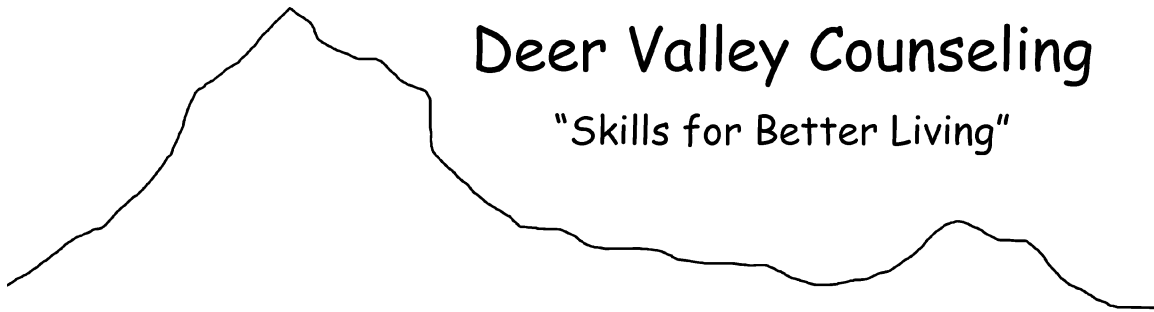
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Referral Source:

- Internet. Search Terms: \_\_\_\_\_  
 Yahoo     Google     Bing     Psychology Today     Kudzu     SuperPages.com     Other
- 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. Appointments made less than 24 hours in advance cannot be canceled or rescheduled.

Payment is expected 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. Since payment is expected at time of service and we are a counseling office, not a billing service, 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.

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

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

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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](http://www.deerval.com)

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.

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.



# Deer Valley Counseling

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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.**



# Deer Valley Counseling

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## Clinicians Notice

November 20, 2009

The State of Arizona requires us to inform you of the following–

1. The Deer Valley Counseling Treatment Team consists of the following members –

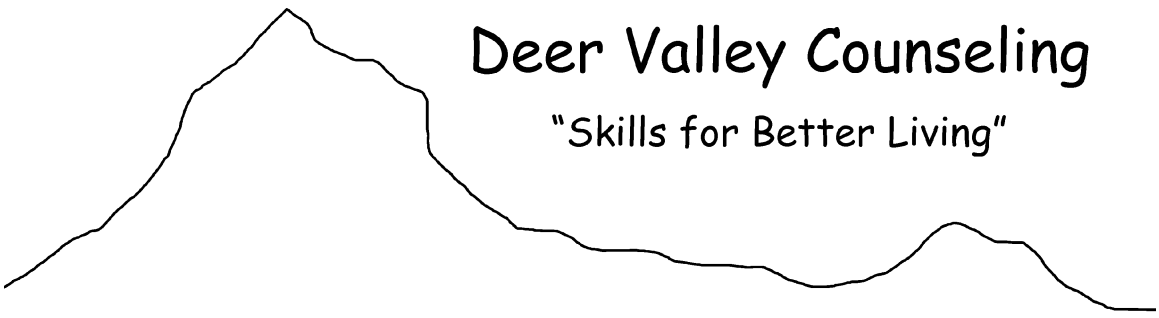
- **Sandra Nettles, Clinical Director.** Sandra has a Master of Science in Social work and is a Licensed Clinical Social Worker, LCSW-10782. Sandra is the direct supervisor of the following clinicians and interns.
- **Amy Davidson, Associate Clinician.** Amy has a Master of Social Work. She is a Licensed Master Social Worker, LMSW-12812.
- **Mary Buckman, Associate Clinician.** Mary has a Master of Arts in Clinical Psychology. She is a Reciprocal Licensed Professional Counselor, RLPC-15030.
- **Joyce Kinikin, Associate Clinician.** Joyce has a Master of Counseling. She is a Licensed Associate Substance Abuse Counselor, LASAC-13083. Her clinical supervisor is Jennifer Williamson, 602.682.6115.
- **Nickie Kinsey, Social Work Intern.** Nickie is a social work student at the Arizona State University. She is an intern working on the second year of her Master of Social Work (MSW) degree.

2. You are a client of Deer Valley Counseling. Your client record is maintained by Deer Valley Counseling.

3. If you have any concerns or questions you can contact Sandra Nettles, Deer Valley Counseling Clinical Director, at 602.750.8051.

Deer Valley Counseling looks forward to serving your counseling needs.

The latest copy of this form can be found under the forms section of the Deer Valley Counseling web site at <http://deerval.com/OtherPages/Forms/CliniciansNotice.pdf>.



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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, Notice of Privacy Practices and Clinicians Notice. 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.

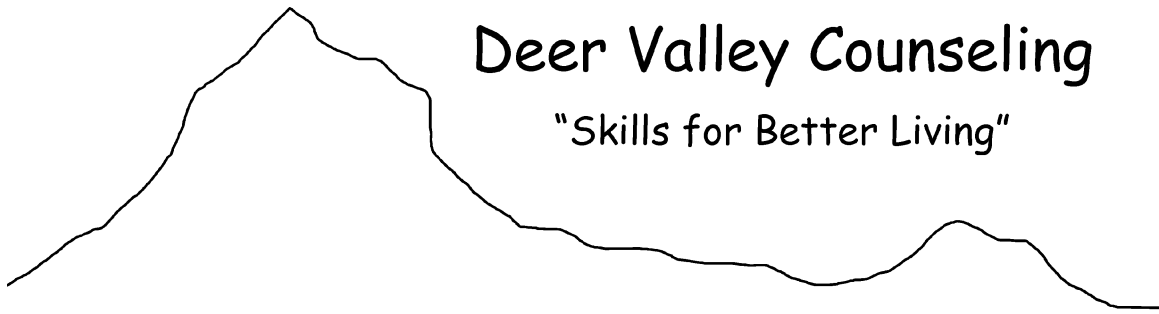
I hereby give my permission for Deer Valley Counseling to charge my credit card on file the full hourly rate for any missed appointments not canceled 24 hours in advance.

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**



# Deer Valley Counseling

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## Treatment Plan, Original or Revised – Child or Adolescent

Name: \_\_\_\_\_

Client Statement of Problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Goal 1: \_\_\_\_\_

Goal 2: \_\_\_\_\_

Goal 3: \_\_\_\_\_

The therapist will fill out this portion.

Treatment Methods:  CBT  Process  Anger Management  Substance Abuse

Other: \_\_\_\_\_

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.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Therapist's Signature

\_\_\_\_\_  
Date

*Attach additional sheets if necessary.*

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