

## Instructions for new client paperwork

Here are the instructions for completing our new client paperwork. It will take approximately 10-15 minutes to fill out. The forms need to be printed out and signed by hand. Please bring the completed forms to your first appointment. If you do not bring the forms, you will need to complete the paperwork in our office. You can not be seen until we have this paperwork on file.

Pages 1 & 2 - "Welcome Page" – This page is yours to keep. Please read over both pages as it contains information about our center and services.

Pages 3 & 4 - "HIPPA Compliance Notice"– We are required to notify you that we are compliant with all HIPPA regulations. Please sign on the second page, all the way at the bottom.

Page 5 - "Adult Intake Page 1" - This form is where we collect contact information. If you will be coming in with someone else (for couples therapy, family therapy, etc.) we only need the information of the primary insurance holder or EAP eligible employee. Please **do not** put more than one person's name, address, date of birth, etc., as we only need the information of the primary insurance holder.

Page 6 – "Adult Intake Page 2" - This is a medical history form. If you will be coming in with someone else (for couples therapy, family therapy, etc.), there is space for both of you to complete this page.

Page 7 - "Financial Policy" - Please read and sign this form. Check the billing option that is appropriate for you.

Page 8 - "Insurance Waiver" - This page details our policy for insurance billing. If we will be billing insurance for you, please read and sign this page.

Page 9 - "Consent for Treatment" - Please read and sign this page. This form gives your permission for us to see you.

Page 10 - "Release of Information" - If you would like us to coordinate care with your primary care physician, psychiatrist, or other health professional, please complete the top portion of this form. Your therapist will complete the bottom.

Page 11 - "EAP/ASSIST Statement of Understanding" -This page explains the EAP/ASSIST programs offered by some employers. If you will be using your EAP/ASSIST benefits, please read and sign this page.

If you have any questions, please feel free to call our office at 928-774-6364. **Please bring this paperwork to your first appointment.** You can not be seen until we have this paperwork on file. Please be sure to bring your insurance card if we will be billing your insurance.

WELCOME TO  
FLAGSTAFF CHILD AND FAMILY COUNSELING CENTER  
408 N. Kendrick, Suite 3  
Flagstaff, Arizona 86001  
(928) 774-6364

We are pleased that you have chosen Flagstaff Child and Family Counseling Center to provide services for you and your family. Please save this sheet so that you have the emergency phone number and a copy of the important policies available for reference. Please feel free to call us if you have any questions.

**EMERGENCIES/MESSAGES:**

For life threatening emergencies call 911.

If you can not reach our receptionist for other emergencies, page the on call therapist by dialing 928-773-5878, listen for the tone and then enter your number so that the on call therapist can call you back. One of our counselors is always on call and/or available in case of emergencies. If more than 15 minutes has passed and we have not returned your call, please page again. The on call number can also be obtained by calling our office at 928-774-6364.

Appointment changes and non urgent messages should be left day or night by calling our office number and leaving a message on either your therapist's or the general voicemail.

**NO SHOW/LATE CANCELLATION:**

**There is a \$35.00 charge for missed appointments unless 24 hours notice is given,** or it is a true emergency. Cancellations can be made by leaving a message on your therapist's voicemail.

**CONFIDENTIALITY:**

Historically, complete confidentiality has applied to communications between psychotherapists and patient. Recently, however, legal developments have occurred which require clarification with regard to confidentiality. Federal law and regulations protect the confidentiality of counseling records including drug and alcohol abuse patient records (HIPPA, see enclosed Client Notice Form.) Generally, our counselors may not say to a person outside the agency that a patient attends counseling or disclose any information identifying a patient unless:

- 1) The patient consents in writing, or
- 2) The disclosure is allowed by court order, or
- 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for a research audit or program evaluation.

**Minors:** Parents or guardians are entitled to information about their children in psychotherapy. However, ethical considerations and the rights of the child require us to communicate such information only in ways that will be helpful.

**CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE RECORDS:**

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by federal law and regulations. Generally, the provider may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol, or drug abuser unless:

- 1) The patient consents in writing, or
- 2) The disclosure is allowed by court order, or
- 3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluations.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for federal regulations.)

### **FINANCIAL POLICY:**

**Payments:** Our policy is to collect from the patient any amounts not covered by the insurance company on the day the services are rendered. Please keep your account current by paying at each appointment by check, cash, or credit card. Accounts that are not current will be billed at the end of the month and all payments are due on the 15<sup>th</sup> of the month following service. A service charge of 10% may be assessed on accounts that are 60 days past due. There may be a \$10.00 handling fee charged for returned checks. Should a financial situation arise that hinders you from making payments on time, we ask that you call our office manager to discuss the situation. If we are informed that there is a problem, we will do our best to work with you in keeping your account current.

**Insurance:** Please read your policy books and /or talk to your benefit's director to be fully aware of any limitations or exclusions. Bring your insurance card with you. **You are responsible for any charges the insurance does not pay.**

**Miscellaneous:** From time to time there will be miscellaneous charges, i.e. letters to interested parties, telephone charges, court appearances, etc. These charges will normally not be paid by insurance and will be your responsibility.

**Collections:** Should an account become 60 days past due it will be subject to our collections process. We use an independent agency for our collections. Besides the charges for services, you will also be responsible for the collection agency fees. By signing the financial policy you are agreeing to have your name and unpaid charges turned over to the collection agency.

**Dependant Children:** The parent/guardian signing the intake paperwork for a child will be financially responsible for all services rendered for that child. Payment is expected at the time of service.

### **BILLING:**

We have full time office support staff (8:00 A.M. to 4: 00 P.M.) to assist you with matters pertaining to billing and Insurance. Please call our office administration if you have any questions about billing at (928) 774-6364.

### **NOTIFICATION TO CLIENTS ON TERMINATION OF PRACTICE**

Therapists will notify all current clients by phone, letter, or in person should they terminate their practice. The notification will include specific information on how clients can obtain their medical records. For other clients, the therapist will post a notice in the newspaper for two weeks regarding the closure of the practice and information for obtaining medical records. More complete protocols in case of practice closure or death can be obtained from your therapist.

Flagstaff Child and Family Counseling Center, PLLC  
408 N. Kendrick, Suite 3  
Flagstaff, AZ 86001  
(928) 774-6364 Phone (928) 556-0504 Fax

## NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA) for Protecting Client Behavioral Health Information

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

### I. Uses and Disclosures of your health information

We may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes without your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. This does not apply to EAP billing.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within FCFCC such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of FCFCC such as releasing, transferring, or providing access to information about you to other parties.

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.

### II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following limited circumstances:

- *Child Abuse* – We are required to report PHI to the appropriate authorities when we have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- *Adult and Domestic Abuse* – If we have the responsibility for the care of an incapacitated or vulnerable adult, we are required to disclose PHI when we have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- *Health Oversight Activities* – If various Arizona Boards overseeing mental health services are conducting an investigation, then we are required to disclose PHI upon receipt of a subpoena from a Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Deceased Patients*—We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
- *Medical Emergencies*—We may disclose your PHI in a medical emergency to medical personnel in order to prevent serious harm.
- *Family Members involved in your care*—We may disclose information to family members directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- *Law Enforcement*—We may disclose PHI to a law enforcement official as required by law, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime or 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 US 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.
- *Research*—PHI may only be disclosed after a special approval process.
- *Serious Threat to Health or Safety* – If you communicate to us an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and we believe you have the intent and ability to carry out such a threat, we have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If we believe there is an imminent risk that you will inflict serious harm on yourself, we may disclose information in order to protect you.
- *Worker's Compensation* – We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

#### IV. Client's Rights

##### Client's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you 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 Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a paper or electronic copy (or both) of PHI in our mental health and billing records, and any other records used to make decisions about you, for as long as the PHI is maintained in the record. We may deny your access to PHI only where there is compelling evidence that access would cause serious harm to you. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. You have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement.
- *Right to an Accounting of Disclosures*– You generally have the right to receive an accounting of disclosures of your PHI. On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.
- *Breach notification* – If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

#### V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Kristen Flugstad or Tina Culhane in this office. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW Washington, DC 20201. We will not retaliate against you for filing a complaint.

#### VI. Effective Date, Restrictions, and Changes to Privacy Policy

- This notice will go into effect on July 1, 2010.
- It is our practice to disclose the minimal amount of information from your record that is necessary to meet the purpose of the situation at hand.
- We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We reserve the right to changes the terms of this notice, and will provide you with a copy of the revised practices by posting a copy on our website or providing one to you at your next appointment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

|                                                     |
|-----------------------------------------------------|
| <b>OFFICE USE ONLY</b><br>ID # _____<br>EAP # _____ |
|-----------------------------------------------------|

DATE \_\_\_\_\_

**CLIENT INFORMATION:**

LEGAL NAME \_\_\_\_\_  
 MAILING ADDRESS \_\_\_\_\_  
 CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_  
 CELL PHONE \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
 SOCIAL SECURITY # \_\_\_\_\_  
 MARITAL STATUS \_\_\_\_\_  
 EDUCATION LEVEL \_\_\_\_\_

**EMERGENCY CONTACT:**

FULL NAME \_\_\_\_\_  
 TELEPHONE \_\_\_\_\_  
 RELATIONSHIP \_\_\_\_\_

**INSURANCE INFORMATION:**

PRIMARY POLICY HOLDER \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ SSN# \_\_\_\_\_  
 EFFECTIVE DATE \_\_\_\_\_  
 INSURANCE ID# \_\_\_\_\_  
 GROUP # \_\_\_\_\_ CO-PAY \_\_\_\_\_  
 DEDUCTIBLE AMOUNT \_\_\_\_\_  
 PRE-AUTHORIZATION # \_\_\_\_\_  
 INSURANCE NAME \_\_\_\_\_  
 ADDRESS \_\_\_\_\_  
 CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**RESPONSIBLE PARTY:**

FULL NAME \_\_\_\_\_  
 MAILING ADDRESS \_\_\_\_\_  
 CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 TELEPHONE \_\_\_\_\_

**SPOUSE/SIGNIFICANT OTHER (IF APPLICABLE):**

NAME \_\_\_\_\_  
 BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_  
 MAILING ADDRESS \_\_\_\_\_  
 CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 TELEPHONE # \_\_\_\_\_

**EAP BENEFIT INFORMATION:**

EMPLOYEE'S FULL NAME \_\_\_\_\_  
 PLACE OF EMPLOYMENT \_\_\_\_\_  
 FULL-TIME \_\_\_\_\_ PART-TIME \_\_\_\_\_  
 BUSINESS TELEPHONE \_\_\_\_\_  
 HAS THE BENEFIT BEEN USED BY A FAMILY MEMBER THIS YEAR \_\_\_\_\_  
 IF YOU WERE REFERRED TO OUR OFFICE, PLEASE LIST THE PERSON/DOCTOR/SOURCE YOU WERE REFERRED BY \_\_\_\_\_  
 YEARS AT THE COMPANY \_\_\_\_\_

**CHILDREN & OTHER FAMILY MEMBERS**

| NAME | RELATION | SEX | DOB | AGE | GRADE | SCHOOL/ EMPLOYER | TEACHER |
|------|----------|-----|-----|-----|-------|------------------|---------|
|      |          |     |     |     |       |                  |         |
|      |          |     |     |     |       |                  |         |
|      |          |     |     |     |       |                  |         |

|                                                     |
|-----------------------------------------------------|
| <b>OFFICE USE ONLY</b><br>ID # _____<br>EAP # _____ |
|-----------------------------------------------------|

## ADULT RECORD FORM

Name \_\_\_\_\_

Family Physician \_\_\_\_\_ Current Medications \_\_\_\_\_

Allergies \_\_\_\_\_ Medical Problems \_\_\_\_\_

Previous Counseling? Yes \_\_\_\_\_ No \_\_\_\_\_ When \_\_\_\_\_ Counselor \_\_\_\_\_  
 Problem \_\_\_\_\_

Reason you are here today \_\_\_\_\_

**Please indicate P = past C = current**

| <b>SYMPTOM</b>           | <b>Self</b> | <b>Spouse/Partner</b> | <b>FAMILY CONFLICT STRATEGY</b>                               |
|--------------------------|-------------|-----------------------|---------------------------------------------------------------|
| dizziness                | _____       | _____                 | ___ conflicts rarely discussed                                |
| fainting                 | _____       | _____                 | ___ conflicts handled verbally                                |
| stomach trouble          | _____       | _____                 | ___ physical discipline with children                         |
| headaches                | _____       | _____                 | ___ physical or emotional abuse of children                   |
| sleep difficulties       | _____       | _____                 | ___ physical conflict between adults (hitting, pushing, etc.) |
| appetite disturbance     | _____       | _____                 | ___ physical conflict leading to injury doctor, hospital)     |
| excessive caffeine       | _____       | _____                 | ___ threats or actual use of weapons                          |
| smoker                   | _____       | _____                 |                                                               |
| head injury              | _____       | _____                 |                                                               |
| eating disorder          | _____       | _____                 |                                                               |
| significant weight loss  | _____       | _____                 |                                                               |
| financial problems       | _____       | _____                 |                                                               |
| nightmares               | _____       | _____                 |                                                               |
| no energy                | _____       | _____                 |                                                               |
| excessive sadness        | _____       | _____                 |                                                               |
| mood swings              | _____       | _____                 |                                                               |
| suicidal ideas/gestures  | _____       | _____                 |                                                               |
| anxious or nervous a lot | _____       | _____                 |                                                               |
| hallucinations/delusions | _____       | _____                 |                                                               |
| memory deficit           | _____       | _____                 |                                                               |
| poor concentration       | _____       | _____                 |                                                               |
| violent thinking         | _____       | _____                 |                                                               |
| obsessiveness            | _____       | _____                 |                                                               |
| agitated                 | _____       | _____                 |                                                               |
| legal problems           | _____       | _____                 |                                                               |
| bad childhood            | _____       | _____                 |                                                               |
| problems with relatives  | _____       | _____                 |                                                               |

**PERSONAL SUBSTANCE USE**

In the last year, have you ever drunk or used drugs more than you meant to? \_\_\_Y \_\_\_N

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? \_\_\_Y \_\_\_N

**FAMILY SUBSTANCE ABUSE**

Used by any family member \_\_\_Y \_\_\_N  
 Occasional use \_\_\_Y \_\_\_N  
 Teenager probably uses \_\_\_Y \_\_\_N  
 Drug use interferes with family or job \_\_\_Y \_\_\_N  
 By whom? \_\_\_\_\_  
 Which drugs \_\_\_\_\_

# FINANCIAL POLICY

**Payments:** Our policy is to collect from the patient any amounts not covered by the insurance company on the day the services are rendered. Please keep your account current by paying at the appointment desk by cash, check, or credit card. Accounts that are not current will be billed at the end of the month and all payments are due on the 15<sup>th</sup> of the month following service. A service charge of 10% may be assessed on accounts that are 60 days past due. There may be a \$10.00 handling fee for all returned checks. Should a financial situation arise that hinders you from making your payments on time, we ask that you call our office to discuss the situation. If we are informed that there is a problem, we can do our best to work with you in keeping your account current. Any overpayments will be refunded

**Insurance:** Please read your policy books and/or talk to you benefits director to be fully aware of any limitations or exclusions. ***You are responsible for any charges the insurance does not pay.***

**Miscellaneous:** From time to time there will be miscellaneous charges, i.e., letters to interested parties, telephone charges, court appearances, etc. These charges will normally not be paid by insurance and will be your responsibility.

**No Show/ Late Cancellation:** ***There is a \$35.00 charge for missed appointments unless 24 hours notice is given,*** or it is a true emergency. Cancellations can be made with our 24-hour answering service.

**Collections:** Should an account become 60 days past due it will be subject to our collections process. We use an independent agency for our collections. Besides the charges for services, you will be responsible for the collection agency's fees. By signing this policy, you are agreeing to have your name and unpaid charges turned over to the collection agency.

**Dependent Children:** The parent/guardian signing the intake paperwork for a child will be financially responsible for all services rendered for that child. Payment is expected at the time of service.

I will handle session fees in the following manner:

\_\_\_\_\_ I will pay in full each time

\_\_\_\_\_ The fee is covered under contract with my employer (EAP)

\_\_\_\_\_ I will pay the insurance deductible and co-pay each time and assign insurance benefits to go directly to the provider.

I HAVE READ, UNDERSTOOD, AND RECEIVED A COPY OF THIS FINANCIAL POLICY STATEMENT.  
(Included in the "Welcome" sheet.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Flagstaff Child and Family Counseling Center, PLLC  
408 N. Kendrick, Suite 3  
Flagstaff, AZ 86001  
(928) 774-6364 Phone  
(928) 556-0504 Fax

## INSURANCE WAIVER

As a courtesy to our clients, Flagstaff Child and Family Center would like to assist in the billing of insurance companies for counseling services rendered. Due to possible difficulties with certain insurance companies paying for services, our clinic needs to remind our clients that they are responsible for the following:

1. Payment for unmet yearly deductible at the time of service. If the deductible is unable to be verified at the first session the client will be responsible to pay the usual and customary fee at the time of service. A refund or credit for future sessions will be given if the deductible has been found, at a later date, to have been met at the first session.
2. Payment for the portion of the fee for services rendered which an insurance company refuses to pay. The refusal for payment of services may include individual, marital, psychological evaluations, contested diagnoses, or other services.
3. Payment for the portion of the fee that the insurance company may have agreed to pay, but is delaying payment to the clinic after 90 days.
4. Obtaining a pre-authorization required by the insurance company prior to the first session, or paying in full for the first session and any subsequent sessions without the required pre-authorization.
5. Certain procedures or information required of the client by the insurance company in order for the clinic to be paid by the insurance company.
6. Keeping our clinic informed of any changes in insurance information.
7. Immediate transfer of payment to the clinic by the client should the insurance company pay the client the amount which is owed to the clinic.

We are sorry for any inconvenience to our clients but insurance companies have been refusing more claims, and requiring more procedures. As a result the clinic and the client need to work together more closely when insurance is involved as part of the fee structure.

**I have read and agree with the above stipulations.**

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

# CONSENT FOR TREATMENT

I \_\_\_\_\_, grant Flagstaff Child and Family Counseling permission to provide outpatient behavioral health services to me and/or \_\_\_\_\_ to address the issues that I present the therapist.

I understand that the psychological service offered by Flagstaff Child and Family Counseling is voluntary and I am entering the treatment (or initiating treatment for my child) of my own free will. I understand that I am an active participant in any treatment decision, periodic review or revision of my treatment plan. I understand that I have the right to refuse any recommended treatment and be advised of the consequences of such refusal and potential termination of treatment. I understand that I may terminate treatment at any time.

I understand that information given to my provider will not be shared with any source outside of my insurance company (if applicable) without my written permission, **except where required by law** (for example, danger to self or others or suspected child abuse). **I acknowledge that I have been given a copy of an approved summary of Federal laws and regulations regarding the confidentiality of alcohol and drug patient records under the CONFIDENTIALITY section of the Welcome to FCFCC data form.** I also understand my rights and responsibilities as a client. **(STATEMENT OF RIGHTS AND RESPONSIBILITIES POSTED ON FCFCC BULLETIN BOARD OR AVAILABLE FROM SECRETARY.)**

I understand that I have the right to question the provider of my treatment and to receive a satisfactory explanation. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.

The therapists at FCFCC may provide consultation with each other. If clinically necessary, information might be shared with the other members of the treatment team. Confidentiality will be respected whenever possible. When clinically necessary, consultation outside of FCFCC will be done without identification of the client.

I understand that my therapist and insurance company may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been or that action has already been taken in reliance on this consent. And that if I do not revoke this consent, it will expire automatically one year after the claims have been paid.

A client has the right to request and obtain a copy of their clinical record.

I have read and understood the above.

\_\_\_\_\_  
Client or Parent\Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Flagstaff Child and Family Counseling Center, PLLC  
408 N. Kendrick, Suite 3  
Flagstaff, AZ 86001  
(928) 774-6364 Phone  
(928) 556-0504 Fax

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PHYSICIAN**

Client Name \_\_\_\_\_ DOB \_\_\_\_\_

Member ID Number or Social Security Number \_\_\_\_\_

I hereby authorize the release of the medical information listed below which pertains to my history, mental or physical condition, or treatment including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my physician:

Physician Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

I understand that the release of this information is to permit my physician to monitor my health status and to coordinate all the care which I may receive from specialists. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information may be provided to this recipient only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request. I understand that my therapist may not condition therapy services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

Signature of Client or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Dear Dr. \_\_\_\_\_,

In order to coordinate care, I wish to inform you that your patient \_\_\_\_\_

was referred to me for treatment on \_\_\_\_\_.

Presenting problems: \_\_\_\_\_

\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment Plan: \_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

If you need additional information please contact me.

Sincerely,

\_\_\_\_\_  
Clinician's Name

\_\_\_\_\_  
Signature

# EMPLOYEE ASSISTANCE PROGRAM (EAP/ASSIST) STATEMENT OF UNDERSTANDING

Employee assistance programs are provided by many employers who wish to offer their employees and family members' professional assessment, counseling and referral services.

This information is provided to you to help you better utilize available services.

**FEES:** Sessions within the EAP/ASSIST program are offered at no cost to the employee or family members. Your employer has already paid for the service.

If an employee or family member needs specialized counseling or treatment beyond the sessions offered by the company program, he or she can choose to remain with their Flagstaff Child and Family Counselor or be assisted in locating an appropriate external source. While medical benefits may defray some of the costs of the services provided by these sources, the employee or family member assumes responsibility for such services.

**PRIVACY:** Information concerning the use of the EAP/ASSIST program will not be given to anyone outside the program without your permission unless required by law. Certain state laws require that the staff assume the responsibility for reporting to appropriate parties instances when a person is a danger to him or herself, to others, or when a child or vulnerable adult abuse/neglect is involved.

**SELF REFERRALS:** If an employee or family member initiates a request for assistance, no one will be notified of the individual's written permission.

**SUPERVISORY REFFERAL:** If a supervisor initiates the referral of an employee as the result of a performance discussion, or as a result of a positive substance screen, the supervisor will be notified of attendance at sessions, provided a proper release of information has been obtained.

**VOLUNTARY PARTICIPATION:** Use of the EAP/ASSIST program is voluntary. It is the client's decision whether or not to use (or not use) the services available. In some cases, as noted above, your employer may require participation in the counseling as a condition of employment or as part of the company's substance policy.

I have read and received a copy (if requested) of this information.

---

Signature

---

Date