Desert View Counseling & Consulting, Inc.

13260 N 94th Dr. Suite 100 Peoria AZ 85381 Phone: 623-487-7763
5150 N. 16th St. C163 Phoenix, AZ 85016 Fax: 623-486-8276

Welcome

The clinicians at Desert View Counseling (DVCC) welcome you and want to take this opportunity to acquaint you with information relevant to:

- Treatment for Adults
- Treatment for Persons under Age 18
- Confidentiality / Privacy
- Billing and Payment Policies
- Rights and Responsibilities

Please read this document and talk with your clinician about any questions. When you sign this document, it will represent an agreement between us.

- Desert View Counseling is a group practice consisting of licensed professional counselors, clinical social workers, marriage and family therapists and substance abuse counselors. We offer many different types of services and therapies including group, individual, couples and family therapy to adults, children and adolescents.
- Our purpose is to help individuals and families cope with daily life and deal with inner conflicts that may interfere as you attempt to reach your life goals. We would like to assist you in becoming empowered to successfully change those behaviors that are not working.
- Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be successful, you will have to work on things we talk about both during our sessions and at home. We are committed to providing you with the best possible care and will be pleased to discuss our professional policies and fees with you.

Psychotherapy/Counseling Services

Psychotherapy is not easily described in general statements. There are many different methods and models clinicians utilize to deal with the problems that you hope to address. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through the process. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress as well as an improved ability to meet your life goals. There are no guarantees about what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your clinician will be able to offer you some first impressions of what our work will include and a treatment plan to follow. Please evaluate this information along with your own opinions of whether you feel comfortable working with your clinician. Therapy may involve a significant commitment of time, money, and energy, so please choose a therapist with whom you connect well. If you have questions about our procedures, ask your clinician at any time. If your doubts persist, your clinician will be happy to help you set up a meeting with another mental health professional for a second opinion.

Pets may be present on the premises as some clinicians utilize Pet Therapy. If this is a problem in any way, please notify your clinician to discuss accommodations.

Meetings, Appointments and Emergencies

- Clinicians normally conduct an evaluation that will last from 1 to 3 sessions. During this time, you and your clinician can decide if you have a good fit. A psychotherapy session is usually 45 to 60 minutes, although some sessions may be longer. At first, sessions are often once a week but may be more or less frequent. Rescheduling is necessary at times. Please help us to keep this at a minimum. Not all clinicians work full time at DVCC. Please check with your clinician about their availability.
- Individual therapists provide clients with their individual business phone numbers. If you need to contact your clinician, please leave an informational message directly with that individual (you will be provided with your clinician's direct business cell phone number). Your clinician will strive to return your phone calls within 24 hours. Please use this number if you need to reschedule an appointment. If you have an emergency, call the 24-hour emergency phone number on the back of your insurance card, utilize your preferred hospital emergency room or call 911.
- While your individual therapist may choose to do some limited communication via text or email, we are unable to ensure confidentiality when using these forms of communication.
- To meet your treatment goals it is very important that you attend the sessions you schedule with your clinician. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 business hours advance notice of cancellation. If it is possible, we will try to find another time during the same week to reschedule the appointment. DVCC charges $50 for a failed appointment, including cancellations of less than 48 hours. The charge must be paid prior to scheduling a new appointment. If failed appointments become a hindrance to your success in therapy, your clinician may terminate treatment. Insurance companies do not cover this charge.
- Sessions will not begin until all participating members of the family are present. One person in a family or couple cannot come to the appointment individually without prior consent of the clinician. Medical records can be released only to the participant that is the active client of record. All participants in the therapy sessions will be provided with privacy information and consent to treatment information.
- Phone consultation – insurance companies do not pay for this service so please make arrangements to pay privately for telephonic counseling.

Medical Records

You have a right to review or receive an appropriate copy of your medical records. The request must be submitted in writing. We would prefer to review your records with you so that you may fully understand the information. Privacy laws allow the provider to charge a "reasonable" cost-based fee for providing the medical records to patients. This fee includes the time the clinician spends retrieving, reviewing, and redacting any potentially confidential or harmful information. Our rates are posted in the office and include a $50 review and retrieval fee as well as a minimal charge per page. DVCC processes record requests within thirty (30 days). Please make requests to allow for the processing time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal information for reasons other than treatment, payment, or other related administrative purposes.

Confidentiality and Client Rights

Information regarding your services and issues discussed in therapy are important and are generally protected and kept confidential according to the Arizona statute and privacy regulations. Desert View Counseling & Consulting, Inc. primarily uses your personal health information for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. However, there are some legal limits to the "privilege" of confidentiality. Confidential information maybe disclosed under the following conditions:

- You request information to be released after completing a written Release of Information
- When there is suspected abuse or neglect of a child, elderly person or disabled person reported
- When your clinician believes you are in danger of harming yourself or another person or you are unable to care for yourself
- If you report that you intend to physically injure someone, the law requires your clinician to inform that person as well as the legal authorities
- As requested by your insurance company for billing or quality management purposes
- As ordered by the Court to release information.
- Your clinician may disclose your information to other DVCC licensed clinicians for purposes of supervision, peer consultation, or coordination of services. Your clinician occasionally finds it helpful to consult other professionals about clinical situations. The "consultant" is also bound to keep the information confidential.
- We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition. Health professionals, using their best judgment, may disclose to a family member, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- When we determine it is in your best interest to coordinate care with other health professionals, such as in a medical emergency.

Other information relating to your privacy and treatment:

- As you are aware, it is impossible to protect the confidentiality of information transmitted via email, text messaging or other electronic media. Please communicate using these methods accordingly.
- You may revoke any authorization for release of records that you may have previously provided.
- Desert View Counseling may change its policies at any time. Changes made to our policies will be made available.
- You will be expected to participate in treatment decisions, the development of a treatment plan, and the periodic review of the plan.
- You have the right to withdraw from treatment at any time and be advised of the consequences.

Providing Feedback

DVCC supports your right to have a complaint heard and resolved in a timely manner. If you have a complaint about your treatment, clinician, or any office policy, please inform us immediately. If you do not feel the complaint has been resolved, please contact one of the business owners by calling the office manager, or you may inform you insurance carrier.

Secure Storage, Transfer, & Access of your Records

- In accordance with Arizona Law, DVCC is required to inform you that your records will be securely stored.
- During treatment, records are kept in a secure onsite location and maintained in a secure offsite location for a period of at least 7 years after termination of treatment, If the client is a minor during treatment, the records will be maintained for a period of 7 years after the 18th birthday of the client. After the minimum record maintenance period the records will be destroyed by means of shredding of documents.
- Should your clinician leave the practice, your records will be maintained and stored for the required time period by DVCC.

Couple/Marital/Family Counseling

- Check with your clinician if a participant cannot attend, as usually sessions cannot be held without all members present.
- Couple and family sessions will be billed only in the name of one of the participants in most situations. This individual has the right to release or not release information from the record unless alternative arrangements are made with all participants.
- The Rights of Privacy of Information belongs to the "specified" client unless the individual signs a Release of Information for other family members or participants. Confidentiality of information in the chart, including information provided to DVCC by any participant, is protected by both federal and state law. The information contained in the medical record may only be released if the "specified" client authorizes DVCC to do so. Only the "specified client" may access or release the medical record information unless an active Release of Information is in place.

Billing and Payments

- The hourly rates for therapy as well as other services such as writing a report or letter, telephone conversations longer than 10 minutes, court testimony and medical record copies, etc., are posted in the office and are in accord with the standard community rates as well as with the insurance companies for whom we have contracts.
- It is important you understand your insurance coverage is a contract between you and your insurance company and that **you are ultimately**
- **responsible** for the payment of your account.
- It is your responsibility to familiarize yourself with your insurance benefits. We will bill your insurance company one time; however you are financially responsible regardless of insurance coverage.
- You will be expected to pay for each session at the time it is held, unless you have insurance coverage which requires another arrangement. (In circumstances of unusual financial hardship, DVCC may be able to negotiate a payment plan)
- Some insurance companies pay you directly, and in that situation you are responsible to pay at the time of the service.
- Billed balances are due and payable within 30 days. Prior authorization for services is required by some insurance companies, but is not a guarantee of payment. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, Desert View Counseling has the option of using legal means to secure the payment. This may include utilizing a collection company. If legal costs are necessary, those costs will be included in the claim.
- Please keep track of the number of sessions your insurance company has authorized and talk with your clinician about the process required by your plan to authorize additional sessions. We do not regularly bill you for services, as all payments are due at the time of the service.
- If you plan to use your Employee Assistance Plan to pay for your 1st several sessions, please understand YOU MUST obtain authorization PRIOR to the day of your service. If the prior authorization and EAP information isn't provided prior to the service, DVCC will bill the medical insurance plan on file for that date of service. You will be responsible for applicable copays or coinsurance. We will not hold the service and bill it later.

Termination of Treatment Services

- Treatment will end when the treatment goals have been accomplished, or the clinician may terminate treatment when the client is not following / actively participating in their treatment as prescribed. The clinician will discuss the situation and a new plan will be formulated or will assist the client in locating referral sources, community options, and supports as appropriate.
- The client may end treatment at any time. Please feel free to discuss your thoughts about this at any time during your treatment.
- Attending scheduled sessions is important to your success in therapy. Clinicians may terminate therapy if regular attendance hinders your progress.
- Treatment may change if your clinician determines you need a more intensive or different type or level of care.
- Termination may be necessary if your clinician determines the clinical atmosphere is not conducive to successful outcomes.

Consent to Bill Credit Card

My signature below indicates my authorization for Desert View Counseling & Consulting, Inc., to save the credit card information I provide and to bill, for agreed upon services, the credit card I have provided. The card will be kept confidential and only authorized staff will have access to the information. Having health care insurance is not a guarantee of payment or coverage for services. As a result, my supplied credit card will be charged ONLY under the following circumstances:

- For therapy session copays, coinsurance, private pay, deductibles as discussed between myself and a Desert View Counseling provider.
- For No Show or Late Cancel Fees as discussed with my provider.

I may rescind this authorization at any time. The authorization will remain in effect until cancelled. I understand that all payments (not covered by insurance) are due at the time of service.

Name _____

Billing Address _____

_____-

Card Type: _____

CC# _____

Expiration Date _____

3 digits _____

Signature _____ Date _____

Text Appointment Reminder Authorization

We can send you appointment reminders by Text Message. The appointment reminder will include only the date and time of your appointment and your service provider name. We will not encrypt the messages. Health care information sent by text message could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by Text Message, Desert View Counseling needs you to confirm you accept responsibility for these risks and your acknowledgement that Desert View Counseling will not be held responsible for any event that occurs after we send the message. If you agree to these conditions, please print your name and phone number legibly in the space provided and sign.

Phone number authorizing to receive Text Messages (print legibly) _____

_____

Print Name of person receiving Text Messages (client, parent or guardian)

_____

Signature of Consent DATE_____

Please initial and sign the following Informed Consent / Assignment of Benefits:

I, the undersigned, voluntarily consent to participate in behavioral health evaluation and treatment by Desert View Counseling & Consulting Inc. I understand that I may withdraw from treatment at any time. Information about the services of Desert View Counseling & Consulting Inc. have been provided, including treatment expectations and my rights as a client.

Assignment of Benefit

_____ I have been informed of my rights about privacy. I authorize Desert View Counseling & Consulting, Inc. to disclose information concerning my diagnosis and treatment as necessary to obtain reimbursement from the payor source. I hereby assign 3rd party payments for services provided to Desert View Counseling & Consulting Inc. I have been informed about my treatment benefits and risks.

Informed Consent

_____I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment and I have been informed of my financial obligation. My signature indicates acknowledgement of all 4 pages of this document.

Communication with my Primary Care Physician:

_____I do NOT wish to have my primary clinician coordinate care and communicate with my Primary Care Physician at this time and understand I can change this consent at any time.

_____I do wish to have my clinician coordinate care with my physician. This requires my primary clinician at DVCC to obtain a Release of Information and send a letter of notification about this visit to the physician listed below.

Physician Name _____

Physician Address _____

_____ **I do or** _____ **I do not** have a mental health advanced directive.

_____ _____

Client Printed Name Client Signature Date

_____ _____

Other participant's signature Date

_____ _____

Other participant's signature Date

_____ _____

Parent/Legal Guardian Print & Signature Date

_____ _____

Parent/Legal Guardian Print & Signature Date

_____ _____

Clinician Signature Date

Desert View Counseling & Consulting, Inc.
13260 N 94th Dr. Suite 100 Peoria AZ 85381 Phone: 623-487-7763
5150 N. 16th St. C163 Phoenix, AZ 85016 Fax: 623-486-8276

Client Information

Name: _____
Last First Mid. Init.

Date of Birth:_____ Social Security Number:_____

_____
Address City State Zip

Primary Phone Number:_____ Alt. Number:_____

Emergency Contact:_____
Name Phone Number Relation

Referring Source

☐ Insurance Company ☐ Doctor's Office_____ ☐ Website ☐ Friend

☐ Hospital ☐ Case Worker ☐ EAP ☐ Other _____

Responsible Party Information
(For Client's Under 18)

Relation: ☐Mother ☐ Father ☐Legal Guardian

Legal Guardian/Parent Name: _____
Last First Mid. Init.

Date of Birth:_____ Social Security Number:_____

_____
Address City State Zip

Primary Phone Number:_____ Alt. Number:_____

Relation: Mother Father ☐ Legal Guardian

Legal Guardian/Parent _____
Last First Mid. Initial.

Name: Date of Birth:_____ Social Security Number: _____

_____
Address City State Zip

Primary Phone Number_____ Alt. Number_____

Primary Insurance Information

Insurance Company	Id#	Customer Service Phone Number
Primary Subscriber Name	Date of Birth	Social Security Number
Subscriber's Employer		Relation To Client

Secondary Insurance Information

Insurance Company	ID#	Customer Service Phone Number
Primary Subscriber Name	Date of Birth	Social Security Number
Subscriber's Employer		Relation To Client

Employee Assistance Program (EAP)

EAP Company		EAP Contact Phone Number
Employee's Name	Date of Birth	Social Security Number
Employer Sponsoring EAP		Employee's Relation To Client

Authorization or Case Number *(If EAP has provided you with this information)*

Desert View Counseling & Consulting, Inc.
13260 N 94th Dr. Suite 100 Peoria AZ 85381 Phone: 623-487-7763
5150 N. 16th St. C163 Phoenix, AZ. 85016 Fax: 623-486-8276

Desert View Counseling Intake Assessment – Completed by client or parent(guardian)

This document has been completed by _____

Relationship to client: ☐Self ☐Spouse ☐Parent ☐Step Parent ☐Legal Guardian

Client Name: _____

☐ **Female** ☐ **Male**

Date of Birth: _____/_____/_____

On What # can we leave a confidential voicemail:

☐ **Home:** _____

☐ **Cell:** _____

Employment

- ☐ Employed by _____
- ☐ Unemployed _____
- ☐ Self Employed _____
- ☐ Retired from _____
- ☐ Disabled due to _____
- ☐ Student @ _____

Significant Others: List the people who live in your household.

Name	Age	Sex	Relationship

History of Prior Treatment (Who, Dates, Reason)
Previous Outpt Counseling? _____
_____
Current Treatment by a psychiatrist?
_____
Prior Inpatient (hospital) psychiatric treatment? _____
_____

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Medical History
Primary Care Physician _____
Address _____
Phone # _____

Current Medical Problems _____
_____
Allergies to Medications or Foods _____

_____
_____

Medication
Current Medications and dosage.

1. _____
2. _____
3. _____
4. _____
5. _____

Client Name _____

Family Mental Health History

1. Has a close relative ever been hospitalized for a psychiatric illness? _____
2. Does Anyone in your family have a mental illness? _____
3. Has anyone in your family ever attempted or committed suicide? _____
4. Does anyone in your family have a substance abuse problem? _____

Educational and Legal History

Are you required by courts to counseling?
☐ Yes ☐ No

Are you engaged in any legal issues at this time?
☐ Yes ☐ No

Have you ever been convicted of a felony?
☐ Yes ☐ No

What is your highest level of education?

_____

Career / Life Goals_____

_____

List and/or describe the changes you would like to make through therapy/counseling.

1.
2.
3.
4.

List or describe the stressors you are currently experiencing.

1.
2.
3.

Adults
I am concerned about:
(check all that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Marriage/relationship
- ☐ Health
- ☐ Job/School
- ☐ Loss
- ☐ Poor choices
- ☐ Social Life
- ☐ Substance Abuse
- ☐ Other _____

Adolescents/Children
I am concerned about:
(check all that apply)

- ☐ School
- ☐ ADHD
- ☐ Academics
- ☐ Substance Abuse
- ☐ Blended Family Issues
- ☐ Anxiety
- ☐ Depression
- ☐ Social Skills
- ☐ Relationships
- ☐ Other _____

Family Psychiatric History: List other family members who have had mental health concerns.

	Who	**What was the Concern**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Legal History: _____

_____

Client Signature_____ Date _____

Parent/Guardian Signature _____ Date _____

Reviewed by Therapist Signature _____ Date _____