New Client Information

Name_____ **Date**_____
Last *First* *MI*

DOB_____ **Age**_____ ____**Male** ____**Female**

Address_____
Street Address (No P.O. Box) *Apt. Number*

_____
City *State* *Zip*

May we send you treatment related information to that address? Y N

May We Leave Message?

Phone Home _____ _____
Cell _____ _____
May we send text messages to cell number listed? (circle) Yes or No
Email _____ May we email you? (circle) Yes or No

Referred by or how you heard about us_____

Marital Status
☐ Married ☐ Single ☐ Cohabitation ☐ Divorced ☐ Dating
☐ Engaged ☐ Widowed ☐ Remarried ☐ Separated
Years Married_____ Age Married_____ Previously Married (If so, how long?)_____

Partner's Name_____ Partner's age____ Date of birth_____

Ethnic background_____

Emergency contact information

Name_____ Relationship_____

Phone_____ Email_____

Occupation/Grade Level_____

Place of Employment/School _____

Names, ages, and birthdates of children_____
_____
_____
_____

Medical and Health Information

Primary Physician_____ Phone_____
Psychiatrist_____ Phone_____
Other Providers_____ Phone_____

Medications and/or supplements
_____
_____
_____
_____

Exercise Type/Intensity/Frequency_____
Number of Pregnancies_____ Miscarriages_____ Abortions_____

Please list any past or present medical issues or concerns
_____
_____
_____

What are your goals for coming to therapy? _____
_____
_____

Have you ever seen a professional counselor before?_____
Why were you seeking help? _____
Was counseling beneficial? _____
Who was your counselor? _____
Have you been to an inpatient or outpatient program? If yes, when?_____
_____
_____

Put initials for all that apply in the past year for each person attending counseling

Frequently sad or depressed		No interest in hobbies	
Frequently anxious		Financial difficulties/ excessive debt	
Mood swings		Excessive anger or rage	
Easily upset or angered		Excessive conflict	
Withdrawn or isolative		Repeat certain behaviors over and over	
Feeling lonely		Difficulty getting up in the morning	
Cry easily/often		Difficulty finishing tasks	
Change in sleep pattern		Insomnia	
Change in appetite		Nightmares	
Significant change in weight		Difficulty with work or school	
Feeling hopeless		Excessive sweating	
Excessive worry		Headaches/migraines	
Difficulty making a decision		Dizziness	
Fatigue		Fainting spells	
Trouble concentrating		Stomach aches	
Extreme dislike of appearance		Unable to relax	
Feeling different from most people		Thoughts/Behaviors of hurting yourself	
Change in sexual behavior/libido		Thoughts/Behaviors of hurting others	
Difficulty with motivation		Other:	

Signature of person completing form_____

Date_____

PRIMARY INSURANCE INFORMATION

If paying privately, please check here ( )

Relationship to Insured ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Child

Policy Holder's Name_____ Date of Birth_____

Social Security #_____ Employer_____

Insurance Co_____ Phone Number_____

ID #_____ Group #_____ Effective Date_____

Type of Coverage ☐ Individual ☐ Family ☐ Individual & Spouse

I authorize disclosure of all necessary information to my insurance company listed above.

Signature_____

Date _____

Notice of Privacy Practices

This notice describes how Empowerment Treatment & Counseling Center for Wellness (ETCCFW) may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations. It also describes ETCCFW's legal obligations concerning your PHI and your rights to access and control your PHI. This notice takes effect on **April 14, 2003** in accordance with the privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations").

PHI refers to individually identifiable health information, including actual medical information as well as your name, address, phone number, identification number or other identifiers, collected from you or created by or received by a health care provider, a health plan, or your employer and that relates to: 1) your past, present, or future physical or mental health condition; 2) the provision of mental health care to you; or 3) the past, present, or future payment for health care provided to you.

ETCCFW is required by law to maintain the privacy of your PHI. ETCCFW is obligated to provide you with a copy of this Notice and ETCCFW must abide by the terms of this Notice.

Uses and Disclosures of Protected Health Information (PHI)

Your PHI may be used and disclosed by your primary behavioral health provider (counselor and/or case manager), ETCCFW office staff and others outside of ETCCFW offices who are involved in your care and treatment for purposes of providing health care services to you, to pay your health care bills, to support the operation of ETCCFW practices, and any other use required by law.

Treatment ETCCFW may use and disclose your PHI to provide, coordinate or manage your health care and other services related to your health care. This includes the coordination or management of your health care with a third party such as when ETCCFW staff consult with the criminal justice agent(s) you report to, or another health care provider, such as your family physician or another behavioral health professional.

Payment Your PHI may be used, as needed, to obtain payment for your health care services. For example, ETCCFW may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

Health Care Operations ETCCFW may use and disclose your PHI for our health care operations. These activities include, but are not limited to: Quality assessment and improvement activities; employee review activities; training of behavioral health students; licensing and conducting or arranging business-related matters such as audits and administrative services, and case management and care coordination. The Bureau of Medical Facilities Licensing may also review client charts upon annual or other inspections.

Business Associates ETCCFW contracts with individuals and entities (business associates) to perform various functions on our behalf, which involves the use and/or disclosure of PHI. Business associates must agree in writing to appropriately safeguard your information. For example, ETCCFW may disclose your PHI to a business associate to transport information from one ETCCFW location to another or to store medical records.

Uses and Disclosures Requiring Authorization

ETCCFW may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your written authorization is obtained. In those instances when ETCCFW is asked for information for purposes outside of treatment, payment or health care operations, ETCCFW staff will obtain an authorization from you before releasing this information.

- You may revoke all authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that ETCCFW has taken an action in reliance on the use or disclosure indicated in the authorization. **However, for persons court-ordered or on probation or parole, if consent is given for disclosure to the criminal justice system, this consent may not be revoked.** (See 42 CFR, Part 2 for federal regulations governing confidentiality of alcohol and drug abuse clinical records.)

Uses and Disclosures with Neither Consent nor Authorization

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

- **Required by Law** – ETCCFW staff may use or disclose PHI in keeping with the law.
- **Public Health** – ETCCFW staff may use or disclose PHI for the purposes of controlling disease, injury or disability.
- **Child Abuse** – ETCCFW staff are required to report PHI to the appropriate authorities when there are reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- **Adult Abuse** – If you have the responsibility for the care of an incapacitated or vulnerable adult, ETCCFW staff are required to disclose PHI when there are 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 the Arizona Department of Health Services or other oversight entity is conducting an investigation, then ETCCFW is required to disclose PHI upon receipt of notice.
- **Legal Proceedings** – ETCCFW may disclose your PHI: 1) in the course of any judicial or administrative proceeding; 2) in response to an order of a court; and 3) in response to a subpoena, a discovery request, or other lawful process.
- **Serious Threat to Health or Safety** – If you communicate to any ETCCFW staff an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and it is believed you have the intent and ability to carry out such a threat, ETCCFW staff 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 staff believe there is an imminent risk that you will inflict serious harm on yourself, staff may disclose information in order to protect you.
- **Worker's Compensation** – ETCCFW 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.
- **Appointment Reminders** – ETCCFW staff may use or disclose PHI to set up appointments or provide you with appointment reminders (such as answering machine/voicemail, letters).
- **Potential Impact of State Law** – In some situations, the HIPAA Regulations do not take the place of state privacy or other laws that provide individuals greater privacy protections. As a result, the privacy laws of Arizona, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which ETCCFW will be required to operate. For example, records from drug and alcohol programs may be subject to additional restrictions. (See 42 CFR, Part 2 for federal regulations governing confidentiality of alcohol and drug abuse clinical records).

Client's Rights and Empowerment Treatment & Counseling Center for Wellness Staff Duties

- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI in ETCCFW's clinical and billing records used to make decisions about you for as long as the PHI is maintained in the record. ETCCFW may deny your access to PHI under certain circumstances (such as information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI). If you request a copy of the information, ETCCFW may charge a fee for the costs of copying, mailing, or other supplies associated with your request.
- **Right to Request a Restriction** – You have the right to request restrictions on certain uses and disclosures of protected health information. However, ETCCFW is not required to agree to a restriction you request. If ETCCFW agrees to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you or unless the use or disclosure is otherwise permitted or required by law.

- **Right to Request to Receive Confidential Communications by Alternative Means or 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 in treatment at ETCCFW). On your request, ETCCFW will send you communications at another address.
- **Right to Request Amendment of PHI** – You have the right to request an amendment of your PHI (in writing with an explanation of why the information should be amended) from the ETCCFW staff you are working with. ETCCFW may deny your request under certain circumstances.
- **Right to an Accounting** – You have the right to receive an accounting of certain disclosures (other than for treatment, payment, and healthcare operations) made by ETCCFW staff or our business associates of your PHI. Your request may be for disclosures made up to 6 years before the date of your request, but may not include disclosures made before April 14, 2003. If you request an accounting more than once in a 12-month period, ETCCFW may charge you a reasonable fee for responding to these requests.

Complaints

If you are concerned that ETCCFW has violated your privacy rights, or you disagree with a decision staff made about access to your records, you may contact the Empowerment Treatment & Counseling Center For Wellness Privacy Officer, Caryn Attianese.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The Empowerment Treatment & Counseling Center For Wellness Privacy Officer, Caryn Attianese, can provide you with the appropriate address upon request.

Empowerment Treatment & Counseling Privacy Officer

You can contact the Empowerment Treatment & Counseling, Attention: Caryn Attianese, Privacy Officer, at (623) 810-1663, 5940 W. Union Hills Drive, Building D, Suite 200, Glendale, Arizona 85308 to:

1) Request access to your PHI
2) Request a Restriction on Use and Disclosures
3) Request to receive confidential communications by alternative means
4) Obtain an Accounting for Disclosures Request Form
5) File a complaint

Informed Consent

Welcome to our office. We look forward to working with you. We have provided the following guidelines to assist you in becoming familiar with our professional services and business policy. In addition to this document, you have been provided a document that contains information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. By signing this document, you agree to understanding all the policies, including HIPAA, and it is an agreement for us to work together. We can discuss any questions you may have now or in the future.

Psychological Services

We want to commend you for taking the first step in this journey and we are honored to walk the path with you. It takes courage to look at yourself and explore patterns that have not been working for you and challenging yourself to create new patterns for your future. We are committed to working with you to have your treatment be successful. Treatment varies depending on the personalities of the professional and client, and the particular presenting problem. Every person is different, so every person's approach will be tailored to meet their needs. You always have the right to ask questions about your treatment and are encouraged to be the most vital part of the process. Treatment involves a large commitment of time, money, and energy. In taking this step to help yourself, it is important that you feel comfortable with the professionals with whom you choose to work. If you have questions about alternatives to traditional talk therapy, we would be happy to discuss that with you as well; including but not limited to EMDR, art therapy, play therapy, and psychodrama. Length of therapy is dependent on each individual.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will offer you some first impressions of what our work will include and a treatment plan to follow. Treatment has many benefits and risks. It often involves discussing unpleasant aspects of your life and you may experience feelings of sadness, guilt, shame, anger, loneliness, and frustration. It can be uncomfortable to talk about the circumstances that you find yourself in or that have led up to you seeking help. On the other hand, treatment has been shown to be beneficial for many people and can lead to significant reductions in distress, better relationships, increase in health, and solutions to specific problems. Usually we have spent a lifetime becoming the people we are. Our practice is in helping people change ineffective patterns, old beliefs, and unhealthy behaviors. We help people get in touch with emotions so they can manage symptoms and enjoy a happier, less stressful and more productive life. Treatment calls for a very active effort on your part and people usually find that experiencing uncomfortable

emotions can be difficult. In order for treatment to be most successful, you will have to work on things we talk about during our sessions at home. Our hope is for you to have a successful and productive experience.

Calling to Cancel or Change an Appointment Time

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session please know the following:

If it is within 24 hours of your appointment time (if you have an appointment on Monday, Friday is the day before), you must call the business number to cancel your appointment. Texts or emails will not be considered for a cancelled appointment within 24 hours. If you cancel within 24 hours, there is a $60 fee for the first missed and then your therapist's full fee for every appointment missed after (unless we both agree that you were unable to attend due to circumstances beyond your control).

If it is outside the 24-hour time, you may text or call the above number for a change in your appointment. Please know that we will only be responding to these messages during regular business hours of Monday-Thursday.

It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, we will try to find another time to reschedule the appointment.

You are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Needing to Talk to Your Practitioner for Non-Emergent Issues or Questions

You can always call or email the office for issues that are non-emergent between appointment times. These issues cannot be texted to your practitioner as the business phone is a group phone and not confidential from other practitioners. You may leave a voicemail or send an email, however, be aware that these calls and emails will only be answered during business hours Mon.-Thurs. Please note that sending an email is not HIPAA compliant.

For all emails and phone calls requiring a practitioner to talk with you, there will be a minimum charge of $25 for every 15 minutes it takes to respond or talk through the question or issues. Each 15 min is a charge of $25 and cannot be submitted to insurance.

If your practitioner requests that you check-in between appointments, there will not be a charge.

Emergent Issues

If it is outside of business hours on Mon.-Thurs. and you are in need of emergent assistance, please contact the crisis line at 602-222-9444 or call 911.

If it is during business hours, you can call the business phone number. If you need assistance immediately and no one answers, please call the crisis line. If assistance is not needed immediately, please allow 1-2 hours for a return call on emergency issues.

Insurance
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, our billing service and office staff will assist you by filing claims and ascertaining information about your coverage for the plans we participate with, but you are responsible for knowing your coverage and for letting us know if/when your coverage changes.
You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. By signing this Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.
If we are not a participating provider for your insurance plan, we will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers.

Billing and Payment
Payment is due at the time of service with the billing rates discussed prior to your appointment. You will be asked to sign a financial agreement at your first session. Payment is accepted by cash, check, or card. If you are using a card, we add a $3 service fee to your amount. For any checks returned unpaid, you are responsible for full payment including the returned check fee. Delinquent accounts may be referred to a professional agency for collection. If an account cannot be settled within 60 days, we have the option of hiring a collection agency or small claims court that will require us to disclose confidential information.

Confidentiality
Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.
Please be aware that we are a counseling practice and at times will discuss cases with other providers in the office to seek consultation. At times, we will seek consultation with other mental health professionals outside of the practice, and in that case, we will limit the client's identifying information. The other professionals are also legally bound to keep information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. All such consultations will be noted in your clinical record.
You need to be aware of other contacts with whom we may need to share protected health information (PHI). Those include office staff for administrative purposes, billing, and legal services. All office staff and professionals have an agreement about protecting

your privacy and have agreed not to release any information outside of our practice without permission.

Minors and Parents
Minors age 12 or older and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment we will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication requires the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Custody Issues
It is the policy for our practice for minor children, where legal custody is split (joint) between parents or guardians who are no longer married or cohabiting, to require authorization and signature from both parents on our Informed Consent and Confidentiality Notice prior to the child being seen.

Professional Records
Please be aware that, pursuant to HIPAA, we keep Protected Health Information about you in 2 sets of professional records. One is your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways your problem impacts your life, your diagnosis, the goals we set for treatment, progress toward those goals, your medical and social history, our treatment history, past treatment records that we receive from other providers, reports of professional consultations, billing records and reports that have been sent to anyone. Except in unusual circumstances that involve danger to you/others or where information has been supplied to us by others confidentially, you may examine and/or receive a copy of your Clinical Record, with a request in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. If we refuse your request for access to your records because we may feel it is harmful, you have a right to appeal which we will discuss with you upon request.
In addition, we keep a set of Psychotherapy Notes. These Notes are for our own use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents/analysis of our conversations and how they impact your therapy. They also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record. While insurance companies can request a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written signed

Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive your Psychotherapy Notes unless we determine that such access is clinically contraindicated.
In the event of the death or incapacitation of your treating therapist, we have appointed other professional colleagues at Empowerment Treatment & Counseling to act on the behalf of your therapist to notify you and to make decisions about storing, releasing and/or disposing of our professional records. In the event that your therapist is ill or on vacation, you will be given the opportunity to see another therapist at our practice.

Client Rights
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of PHI. These rights include requesting that we amend your record (must be made in writing), requesting restrictions of what information from your Clinical Record is disclosed to others, requesting an accounting of disclosures of PHI that you have neither consented to nor authorized, determining the location to which protected information disclosures are sent, having any complaints you make about our policies and procedures recorded in your records, and the right to a paper copy of this agreement. We will be happy to discuss any of these rights with you.

Group Practice
Empowerment Treatment & Counseling is a group practice with independently and associate licensed professionals. All counselors within this practice hold a master's degree or higher and are licensed to practice in Arizona by the Board of Behavioral Health. Interns are currently obtaining their master's degree and may also sit in sessions with other professionals. Associate level counselors and interns practice under the direct supervision of Caryn Attianese, MA, NCC, LPC, CEDS and all cases are discussed with her. Your counselor will inform you if they are practicing as an associate level counselor or an intern. Due to this supervision, Caryn will sit in sessions with associate level counselors and interns throughout the course of treatment. If you ever want to contact Caryn you can reach her at (623) 810-1663. If you should have questions or concerns about the way that your treatment is proceeding, please bring your concerns up directly with your treatment provider prior to calling Caryn. Please see our website for backgrounds on each of our providers.

Electronic Communication
There are inherent confidentiality and privacy risks along with limitations of electronic data exchange due to the nature of electronic communications. There is no guarantee of confidentiality through e-mail correspondence or texting. If you choose to communicate with us via e-mail or texting, by signing this agreement, you understand and acknowledge that any information including your name, email address, telephone number, or your correspondence with us is not guaranteed confidential. If there is a confidentiality breach while communicating via electronic methods with us, you agree to release us from any responsibility for the breach.

Other Rights
If you are unhappy with what is happening in therapy, we hope you will talk with us so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, diagnosis or source of payment. You have the right to ask questions about any aspects of therapy and about our specific training and experience.

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Print Name: _____ Date _____

Client Signature: _____

If client is a minor:
Print Parent or Guardian Name: _____ Date: _____

Parent or Guardian Signature: _____

Credit Card Authorization

Please note that we may charge a $3.00 courtesy fee for the use of a credit card. If we run the card without being able to swipe it, there will be a $5.00 fee. By signing this form, you authorize us to apply charges to the credit card listed below. We require that you provide 24-hour notice for canceled appointments. If you are unable to provide us with 24 hours before canceling your appointment or miss an appointment without contacting us, we will charge your credit card for $60 the first time and the full session fee thereafter. You will be informed prior to being charged for a no-show fee or late cancel fee. Please be advised that if you are using insurance, we cannot bill your insurance for missed appointments and will bill the full session fee to you. This authorization is good until you terminate your services.

The undersigned authorizes charges to their credit card for payment of services

Card Type Visa Mastercard American Express Discover

Credit Card Number _____

Expiration Date _____

CCV code _____

Name on the Card _____

Billing Address including zip code_____

_____

Signature of cardholder _____

Date _____

If cardholder is different from client, please list client name _____

We request that you notify us of any changes in your card as soon as possible. Thanks.

Updated 4/2018