Thrive Counseling Services, LLC

2500 S. Power Rd. Suite 120 Mesa, AZ 85209
(480) 203-9653
www.thrivecounselingaz.com

NEW CLIENT REGISTRATION

Name: _____ DOB: _____/_____/_____ Age: _____

Home Phone: _____Work Phone: _____Cell: _____

Do ***NOT*** leave a message on my □ Home □ Cell □ Work number

Okay to text cell# to confirm/cancel/reschedule appointments? Y/ N

Residential Address: _____ City: _____ Zip: _____

Okay to send treatment/billing information to this address: Y / N

If no, please provide an alternate address: _____

Email_____ Okay to use email to confirm appointments? Yes No

Okay to email newsletter & practice announcements? Y / N

Employer: _____ Type of Work: _____

Relationship Status: (circle one) Single/Married/Relationship/Divorced/Separated/Widowed/Other

Emergency Contact: _____*Relationship:* _____*Phone:* _____

By whom were you referred? _____

May I have permission to thank that person? Y / N

What brought you into therapy today? _____

How did you hear about my practice? _____

Reflecting on the last 6 months, please circle all that apply:		
Frequently sad or depressed	Crying easily/often	Mood Swings
Overwhelming worries	Difficulty making a decision	Excessive gambling
Difficulty falling or staying asleep	Difficulty finishing tasks	Feel more talkative than usual
Unable to concentrate	Feeling restless or keyed up	Excessive spending/shopping
Lack of appetite/increased appetite	Restless unsatisfying sleep	Decreased need for sleep (3-4 hrs)
Significant change in weight	Muscle tension	Easily distracted by unimportant things
Low energy level/fatigue	Troubling thoughts about the past	Take too many risks
Feeling excessive guilt or shame	Nightmares	
Unable to relax	Startle easily	Feeling different from most people
Irritable and/or short temper	Too neat and orderly	Easily upset or angered
Loss of interest in activities	Repeating certain behaviors over and over	Shy around others
Feeling hopeless	Thoughts to hurt self	Increasingly forgetful
Feeling worthless	Attempts to harm yourself	Strong fears
Difficulty motivating	Thoughts to hurt others	
Withdrawn/isolating self	Threats to hurt others	

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Medical History

Are you currently being treated for any medical problems? Yes No
Are you currently taking any medications? Yes No

Dosage	Type	For (i.e. depression)	Prescribed by

Do you smoke cigarettes (cigars, chew)? Yes No #_____per day
How much alcohol do you drink? #_____per day _____# per week
Do you use illicit drugs? Yes No
Have you ever tried to cut down or stop using alcohol or drugs? Yes No
Has anyone ever asked you to cut down on your drinking? Yes No

Have you experienced or witnessed a traumatic event? (*parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc) Yes No
Do you have a history of domestic violence? Yes No
Have you been in active combat? Yes No
Do you have a history of verbal, emotional or physical abuse? Yes No
Do you have a history of sexual abuse or sexual assault? Yes No
Have you ever been hospitalized for any emotional/ mental health condition? Yes No

Family History: Have <u>you</u> or <u>anyone in your family</u>, experienced any of the following:

	Relationship of Family Member to you:
Anxiety	
Depression	
Bipolar disorder	
Learning disorders (ADHD, dyslexia, etc).	
Illicit drug use	
Alcohol abuse	
Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

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Informed Consent for Assessment & Treatment

The purpose of this information is to help you to make an informed decision about participating in treatment. Please read it carefully and discuss with me any questions that you may have. A copy of this consent form is available by request.

About the Therapy Process

Most people attend therapy with the goal to find relief of emotional and relational concerns. My approach is to help you increase your emotional awareness, develop skills and work through events that bring you distress. It is important for you to know that therapy has both benefits and risks. Therapy often requires recalling unpleasant events and struggling with troubling issues. Consequently, people sometimes experience uncomfortable feelings such as sadness, fear or loneliness. However, therapy has been shown to have benefits for those who undertake it. Although there are no guarantees about the outcomes of therapy, people often report significant reductions in feelings of distress, satisfactory resolution of specific problems and an improvement in relationships and overall quality of life.

About Me

I am a Licensed Professional Counselor with a Masters Degree in Professional Counseling. I am licensed with the Arizona Board of Behavioral Health Examiners and my license number is LPC-13642. I have my Masters Degree in Counseling from Ottawa University.

Your Rights as a Client

1. You have the right to ask questions about and/or refuse any therapeutic technique or recommended treatment and the right to be advised of the consequences of such refusal or withdrawal.
2. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued. If you wish, I will provide you with the names of other qualified therapists.
3. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan.
4. You have the right to request your medical and billing records. Please see HIPPA form for procedure.

Therapy Services and Fees:

1. Session Fee: **A therapy hour is 50 minutes**. My standard fee is **$150 per 50-minute session**, $300 per 100-minute session (a "double" session) and **$170 for Initial Diagnostic.** You are encouraged to schedule sessions as you feel will be helpful. I will recommend a schedule that I believe will be most beneficial for your goals.

2. Payment: Payment is due at the beginning of the session.

3. No-show/Late Cancel: If you are unable to attend your scheduled appointment, you must call 24 hours in advance or you will be charged a **$50 late cancellation fee**. If you do not show up to the appointment and do not give a late cancellation notice you will be charged the **full session fee**. Additionally, if your personal check is returned you will be charged a $25 fee.

4. Other Fees:

- **Client phone calls**: Calls are charged $25 for every 15 minutes. If call is under 10 min the fee is waived.
- **All other phone calls and services** (i.e. consultation with a psychiatrist, filling out forms, reading extensive emails) charged at $125/hour.
- **Legal:** Any work related to a legal situation (i.e. attorney calls, writing reports & court appearances) ***will be billed at $250.00/hr*** (billed in 15 minute increments). This includes preparation as well as travel time if applicable.
- **Refund**: If a client is due a refund, this will be provided by check or credit within 5 business days of therapist becoming aware of refund amount due.

Therapist Availability & Emergency Procedures

1. This practice does **NOT** have the capacity to respond to counseling emergencies. Emergencies should be directed to **911** or to the local hotlines: **Empact 24-hour crisis line 480-784-1500**, Banner Help Line 602-254-4357, or Mercy Maricopa 602 222-9444. If you have a Psychiatrist, you should also contact him/her in times of emergent need.

2. You may leave a confidential message at any time with my answering service at **(480) 203-9653**. I check messages frequently throughout the day and will return your call as soon as I am able. On weekends and holidays, I check my messages less frequently and may only respond to urgent calls. Non-urgent phone calls are generally returned within 24 hours. If I haven't returned your call within 24 hours, please call again.

3. Email and text communication is for non-emergencies only. It may be used for appointment changes, referrals and non-clinical questions. I check emails as often as possible, but if you are canceling an appointment with less than 24 hours notice, please call the number listed above. I have no way to guarantee the confidentiality of electronic communication so please use at your own discretion. **All non-routine emails/texts will be printed out/transcribed and kept as part of your permanent record.**

CONFIDENTIALITY: *(Please refer to Condensed HIPPA Disclosure for additional information)*
In most cases communications between client and therapist will be held in strict confidence - unless you provide your therapist written permission to release information about your treatment.

1. Therapists are legally mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse to the appropriate authorities. Therapists are also required to notify the police as well as intended victim if it is determined that a client presents a serious danger of physical violence to another person. A therapist may break confidentiality when she believes a client is likely to be dangerous to him or herself.

2. The HIPAA NOTICE OF PRIVACY PRACTICES, posted in this office and available on request, details the considerations regarding confidentiality, privacy, and your records. This Notice contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so.

3. In the event of my death/incapacity, my colleague Amy Safier, LPC, will follow-up with my clients that are actively receiving services (seen within the past month). In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients

will be handled by Thrive Counseling Services, LLC which will be responsible for record requests and destroying records when the legal timeframes for records retention are satisfied.

4. It is common for licensed therapists to participate in consultation and training groups within the mental health community. I regularly meet with other professionals regarding my clients, however, my client's identity remains anonymous, and confidentiality is fully maintained.

Emails, Cell Phones, Computers and Faxes:

Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality. Please notify your therapist if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell-phone/texts or faxes. If you communicate confidential or highly private information via electronic media, Amanda Leno, LPC will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted.

Social Media:

I do not accept friend/contact requests from current or former clients (including children, adolescents and parents) on any social networking site (i.e. Facebook, LinkedIn). I believe that adding clients as contacts on these sites can compromise confidentiality and blur the boundaries of our therapeutic relationship. I believe that adding clients as contacts can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. I do not follow current or former clients on blogs or Twitter. If you are interested, you may like my Thrive Counseling Services page on Facebook and/or Instagram, as it is a public page and there will be no direct communication or contact on this page. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy. If you have questions about this, please bring them up when we meet and we can talk more about it.

Authorization for Evaluation and Treatment

Your signature below indicates that you have had the opportunity to read and review the information in this consent form, that questions regarding your care have been satisfactorily answered and that you have received a copy of this informed consent (by request). It is agreed that either of us may discontinue treatment at any time.

I authorize evaluation and treatment from Amanda Leno, LPC and agree to pay fees for such treatment.

Client signature _____Date_____

Therapist signature _____Date_____
Amanda Leno, MA, LPC

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Agreement to Pay for Professional Services

I request that Amanda Leno, MA, LPC provide professional services and I agree to pay this therapist's fee for all therapy services at the rate outlined in the consent for treatment signed and provided to this therapist during my first therapy session. I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform her that I wish to end it. I agree to pay for services provided to me up until the time I end the relationship, including any late cancellation or no show fees that may have accrued.

I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account. If my insurance company declines to pay for services, I agree that I am responsible for the full fee accrued for each session, $170 for the Initial Diagnostic and $150 for each subsequent therapy session. I have also read this therapist's Consent for Treatment form and agree to act according to everything stated there, as shown by my signature below and on the intake form.

I also consent to release my personal clinical information to my insurance provider so that they may be billed for my services. I give my permission that any/all clinical documentation as requested by my insurance company may be provided.

I understand that this may include but not be limited to:

Clinical assessment including diagnosis, demographic information, copies of my consent to treatment, clinical therapy notes for each session attended, all dates and times of sessions attended, fee/payment information, medical and mental health history as provided during intake, treatment plan, any releases of information or additional clinical notes documented. I consent that my therapist provide any additional clinical documentation that may be requested by my insurance company for payment of mental health services.

_____

Signature of client(s) Date

_____

Printed name of client(s)

_____

Amanda Leno, MA, LPC Date

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Treatment Plan

Please think about your goals in our work together and complete the section below.

1) What is the **first specific goal** – perhaps very small – that if achieved would help you feel like you are moving in the right direction? (Use clear, simple words.)

2) What are other **specific goals that** you hope to attain?

To achieve these goals, what are you willing to do? Check all that apply:
[ ] Attend therapy regularly (how often) _____
[ ] Do homework between sessions
[ ] Collaborate with the therapist in designing my treatment
[ ] Try out some new behaviors my therapist might suggest

Treatment Methods Include: Person-Centered, Psychodynamic, Interpersonal, CBT, Psycho-Education, Expressive Arts, Parenting Consult, Relaxation/Mindfulness Skills, EFT.

Recommendations:
Couples/Family Counseling; Psychiatric Assessment; Follow-up with Medical Practitioner,
Other: _____

Plan to be reviewed on : ___/___/___

Client signature _____ Date: _____

Therapist _____Date: _____
Amanda Leno, MA, LPC

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1 Year Review of Treatment Plan

Treatment Plan Reviewed: ___/___/___ [ ] Continue with goals above and/or [ ] New goal(s):

Client signature _____ Date: _____

Therapist _____Date: _____
Amanda Leno, MA, LPC

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Fee Payment Policy and Credit/Debit Card Authorization Form

****It is the policy of this office to keep a debit/credit card on file. You may pay by cash or check, but a card must still be kept on file.****

Name on Card:

_____

I authorize Thrive Counseling Services, LLC credit card processing to charge my credit/debit card for professional services as follows**:**

- All visits for which payment was not made at time of visit.
- The balance of fees not paid by client 10 days after a written billing statement has been issued to client.
- The balance of fees not paid by insurance company within 90 days.
- **To charge my card $50 for each late cancellation (less than 24 hours notice) or the full session fee for a no-show on the day of the late cancellation/no-show.**

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX

Credit Card Number _____ - _____ - _____ - _____ Expiration Date _____

Card Holder's Address for Credit Card Statements:

_____

CVV Number _____ (3 or 4 digit number usually found on the **back** of the card).

Card Holder Signature _____ Date ____ /_____ /____

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NOTICE OF PRIVACY PRACTICES for Protected Health Information (PHI)

This notice provides you with information about how your protected health information (PHI) may be used and disclosed by this provider, as well as your rights regarding your PHI, including how to access this information. Your PHI includes any identifiable health information, which relates to your past, present or future health, treatment or payment for health care services. I am a licensed therapist, licensed by the State of Arizona through the BBHE. I create and maintain treatment records that contain individually identifiable health information about you. This notice concerns the privacy and confidentiality of those records and the information contained therein. **EFFECTIVE DATE OF THIS NOTICE**. This notice first became effective June 1, 2008.

1. LEGAL DUTY TO SAFEGUARD YOUR *PROTECTED HEALTH INFORMATION* (PHI).

The Health Insurance Portability and Accountability Act (HIPAA) requires me to:

- Maintain the privacy and confidentiality of your PHI as required by law;
- Provide you with a notice as to my legal duties, privacy practices and your rights regarding your medical information.
- Follow the terms of the current notice
- Notify you if I cannot accommodate a requested restriction or request and
- Accommodate reasonable requests regarding methods to communicate health information with you.

I reserve the right to:

- Amend, change or eliminate provisions in my privacy practices and to enact new provisions regarding the PHI I maintain, provided that the changes are permitted by law. If my information practices change, I will amend this Notice.
- Before an important change is made in my privacy practices, I will change this notice, post the revised notice in a clear and prominent location and make the new notice available upon request.

2. USE AND DISCLOSURE OF YOUR PHI WITHOUT YOUR AUTHORIZATION

Federal privacy rules allow health care providers (me) who have a direct relationship with a patient (you) to use or disclose the patient's PHI without the patient's written authorizations, to carry out the health care provider's own treatment, payment or health care operations.

FOR TREATMENT: If I decide to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your PHI, which is otherwise confidential, in order to assist me in the diagnosis or treatment of your mental health condition. The word "treatment" includes, among other things, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

FOR PAYMENT: I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. I may also provide PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims. If your health plan requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy, I am permitted to disclose your PHI.

FOR HEALTH CARE OPERATIONS: If your health plan decides to audit my practice to review my competence, your mental health records may be used or disclosed for those purposes.

ADDITIONAL USES AND DISCLOSURES that do NOT require your consent:

- ***Appointment reminders and health related benefits or services:*** We may contact you by leaving you a voicemail or sending an email to provide appointment reminders or to give you information about treatment alternatives, or other health care services or benefits that we offer.
- ***Workers compensation:*** If you are seeking compensation through Workers Compensation, we may disclose your health information to the extent necessary to comply with laws relating to workers' compensation.
- ***Court Order:*** If disclosure is compelled by a court pursuant to an order of the court.
- ***Adjudication***: If disclosure is compelled by a board, commission or administrative agency for purposes of adjudication pursuant to its lawful authority.
- ***Abuse/Neglect:*** We may disclose your health information to public authorities as allowed/required by law to report suspected abuse or neglect of a child, elder or dependant adult.
- ***To avoid harm:*** To avert a serious threat to your own health or safety or the health or safety of others, we may disclose your PHI consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
- ***When disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement.*** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
- ***For health oversight activities***. For example, I may have to report information to assist the government when it conducts an investigation or inspection of a health provider or organization. The Board of Behavioral Health Examiners, who license Marriage & Family Therapists, is an example of a health oversight agency.
- ***Compliance***: If disclosure is compelled by the U.S. Secretary of Health and Human Services to investigate or determine my compliance with privacy requirements under the federal regulations (the "Privacy Rule.")
- ***Other:*** If disclosure is specifically required by law.
- ***Please note***: The above list is not an exhaustive list but informs you of most circumstances when disclosure without your written authorization may be made. Other uses and disclosures will generally (but not always) be made only with your written authorization.
- I will not disclose your PHI for any purpose not listed above without your specific written authorization. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization).

3. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION

- ***You have the right to request restrictions on certain uses and disclosure of your PHI, such as those necessary to carry out treatment, payment or health care operations****. I am not required to agree to your requested restriction. If I do agree, I will maintain a written record of the agreed upon restriction* and abide by them except in emergency situations.
- ***You have the right to receive confidential communications of PHI from me by alternative means or at alternative locations*** *for example, sending mail to a*n alternate address or to an e-mail instead of regular mail). I will agree to your request so long as it is reasonable for me to do so.
- ***You have the right to inspect and copy PHI by making a specific request to do so in writing.*** However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI l collect in connection with a legal proceeding. I will respond to you within 10 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial

- reviewed. If you request copies of your PHI, I will charge you not more that $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
- **The *Right to Get a List of the Disclosures I have made***. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those named for treatment, payment, or health care operations directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or disclosures made before June 1, 2008.
- ***The Right to Amend Your PHI.*** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 30 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) Correct and complete, (b) not created by me, (c) not allowed to be disclosed, and/or (d) not a part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it and tell others that need to know about the change to your PHI.

If you want to exercise any of the above rights, please contact the Privacy Officer, Amanda Leno, LPC (480) 203-9653. She will provide you with assistance on the steps to take to exercise your rights.

QUESTIONS/COMPLAINTS: If you have questions, would like additional information or want to report a problem regarding the handling of your information, you may contact the Privacy Officer Amanda Leno, LPC at (480) 203-9653. Additionally, if you believe your privacy rights have been violated, you may file a written complaint with the Secretary of the Department of Health and Human Services. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

I have read and received a copy of the HIPAA NOTICE OF PRIVACY PRACTICES, and have had my questions about privacy and confidentiality answered to my satisfaction. I understand the terms of this HIPAA Notice.

Signature _____ Date _____

Signature _____ Date _____