CLIENT INFORMATION

When providing therapy to a child or family the file is usually created under the parent's name so the client's name is usually the name of one of the parents.

Client Name: _____ _____
Last First Date of Birth: (MM/DD/YYYY) Age

Names of others within the family that may also participate in family therapy (I confirm that I am the legal guardian of anyone under the age of 18 who will participate in therapy services, or I have and can provide proof of consent of the legal guardian):

_____ _____ _____

_____ _____ _____

Address: _____
City State Zip

I wish to be contacted in the following manner (initial all that may apply):

_____ Home Telephone: _____
_____ O.K. to leave a message with detailed information
_____ O.K. to contact or respond via text message
_____ Leave message with call-back number only

_____ Cell Telephone: _____
_____ O.K. to leave a message with detailed information
_____ O.K. to contact or respond via text message
_____ Leave message with call-back number only

_____ **OK to be contacted through email. If so, please provide your email address: _____**

Release of Information: I give legal permission to contact the following individuals at the following phone number(s) to discuss my treatment as it relates to the following (initial all that may apply): ____ All aspects of treatment, ____ Engagement in treatment, _____ Financial information only, _____ Attendance only. _____ Attendance and financial only

Name of person to contact: _____ Relationship: _____ Phone # _____

***Signature** of Responsible Party*: _____ Date: _____ Expiration Date: _____
This release of information is good for up to one year and can be revoked at any time by signing. I no longer consent to release information to the individuals above (sign) _____ Date: _____

IN CASE OF EMERGENCY

Nearest Relative

Name: _____
Name Relationship Home Number Cell Number

FINANCIAL RESPONSIBILITY (please fill out if other than primary client)

Name: _____
Name Relationship Home Number Cell Number

I accept full responsibility for all fees due to professional services. I realize that any third party billing is out of courtesy to me and does not transfer any financial responsibilities for unpaid services. I understand that 24 hours notice is required to cancel or change an appointment, and that if 24 hours notice is not given, I am responsible to pay a cancellation charge of $50.00.

Signature of
Responsible Party: _____ Date: _____

ASSESSMENT

WHAT OCCURRED THAT MADE YOU WANT COUNSELING NOW?

WHAT ARE YOUR TOP 3 CONCERNS? (PRESENTING PROBLEMS)

1.

2.

3.

Any other concerns?

PREVIOUS COUNSELING?

Have you, or anyone in your family, ever received psychiatric or psychological help or counseling or any kind? If so, please explain.

MEDICAL PROBLEMS?

MEDICATIONS TAKEN BY CLIENT OR FAMILY MEMBERS?

LEGAL PROBLEMS?

DRUG USE OR ALCOHOL CONSUMPTION PAST OR PRESENT?

Does anyone in the family consume alcohol or any drugs? If so, what and how often? (This information is confidential).

FAMILY HISTORY OF ADDICTION?

Have you or anyone in your family ever had an addiction including addictions to alcohol, drugs, gambling, sex, pornography, video gaming, or struggled with an eating disorder? If yes, please explain.

HISTORY OF ABUSE?

Have you or a family member ever experienced physical or sexual abuse or witnessed violence? Please explain if you feel comfortable or you can leave it blank if you're not comfortable explaining.

SUICIDAL/ASSAULTIVE IDEAS OR HISTORY?

Have you or a family member ever tried to commit suicide or been involved in physical violence?

RELIGIOUS OR SPIRITUAL AFFILIATION?

Does your family practice a formal religion or find strength from spiritual beliefs? If yes, please explain.

CLIENT/FAMILY STRENGTHS?

Please list strengths that you and your family have.

DAILY PATTERNS (CIRCLE ALL THAT APPLY)

Poor sleep **Social Withdrawal** **Anxiety** **Nightmares** **Anger** **Fatigue** **Binging/Purging** **Decreased sexual interest** **Decreased job performance** **Decrease School Performance** **Increase/Decrease apatite** **No impairments**

TO BE FILLED OUT BY THE THERAPIST

Name: _____ DOB: _____ Intake date: _____ Todays Date: _____

DSM IV DIAGNOSIS

Axis I _____
Axis II _____
Axis III Deferred to PCP
Axis IV _____

Mental Status

Well Groomed
Poor Hygiene
Psychomotor Retardation
Suspicious
Agitated
Clothing Disheveled
Pressured Speech
Cooperative
Uncooperative
Other: _____

General Intellectual Functioning

Able to Abstract
Alert
Memory Impairment
Tangential
Decreased Attention Span
Subnormal Intelligence
Fully Oriented
Logical/Goal Directed
Preoccupied with Detail
Disoriented/Confused
Other:_____

Mood/Affect

Anxious
Angry/Hostile
Depressed/Sad
Anhedonia
Euphoria/Elated
Blunted
Appropriate to Content
Inappropriate to Content
Euthymic
Irritable
Other: _____

Thought/Perceptual Content

Obsessions
Delusions
Compulsions
Ideas of Reference
Hallucination/Illusions
Normal
Other:_____

How did you hear about us? _____

If on line what website or search words did you use? _____

Were you referred? Circle YES or NO If so, who referred you? _____

_____

_____

_____

If you are seeking counseling for a child please fill out the following behavior checklist.

CHILD BEHAVIOR CHECKLIST

Child's Name:_____Date:_____Completed By:_____

Please circle **Y** = yes for behaviors that are a concern for your child, **S** = sometimes for behaviors that are sometimes a concern for your child and **N** = no for behaviors that are not a concern for your child.

ATTENTION

When symptoms began (date)_____

Careless mistakes	Y	S	N
Poor attention span	Y	S	N
Doesn't listen	Y	S	N
Doesn't finish tasks	Y	S	N
Problems organizing	Y	S	N
Avoids tasks requiring concentration	Y	S	N
Loses needed items	Y	S	N
Easily distracted	Y	S	N
Trouble remembering/forgetful	Y	S	N
Fidgets, squirms	Y	S	N
Leaves seat when required to sit	Y	S	N
On the go, seems driven	Y	S	N
Runs, climbs excessively/restless	Y	S	N
Talks all the time	Y	S	N
Problems waiting turn	Y	S	N
Interrupts	Y	S	N

OPPOSITIONAL BEHAVIORS

When symptoms began (date)_____

Touchy, easily annoyed	Y	S	N
Argues	Y	S	N
Defiant	Y	S	N
Angry	Y	S	N
Tantrums	Y	S	N
Bothers others deliberately	Y	S	N
Spiteful/mean	Y	S	N
Blames others for own mistakes	Y	S	N

CONDUCT

When symptoms began (date)_____

Bullies/threatens others	Y	S	N
Starts fights	Y	S	N
Used a weapon	Y	S	N
Physically cruel to people/animals	Y	S	N
Forcibly stolen from victim	Y	S	N
Stolen without confronting victim	Y	S	N
Forces sexual activity	Y	S	N
Deliberately sets fires to cause damage	Y	S	N

MOOD

When symptoms began (date)_____

Weight changes/appetite changes	Y	S	N
Energy level changes	Y	S	N
Sleep disturbances	Y	S	N
Difficulty concentrating	Y	S	N
Crying spells	Y	S	N
Loss of interest/pleasure	Y	S	N
Hopeless feelings	Y	S	N
Guilty feelings	Y	S	N
Isolates self	Y	S	N
Low self-esteem/self-hate	Y	S	N
Gives things away	Y	S	N
Wishes to be dead	Y	S	N
Injures self	Y	S	N
Thinks about death/violence often	Y	S	N
Rage outbursts	Y	S	N
Bizarre behaviors, hallucinations	Y	S	N
Rapid, hard to follow speech/thoughts	Y	S	N
Thinks s/he is the smartest, best person in the world	Y	S	N

ANXIETY/WORRY

When symptoms began(date)_____

Worries something terrible will happen to self or important adults	Y	S	N
Frequently refuses or is reluctant to go somewhere fear of separation	Y	S	N
Avoids being alone	Y	S	N
Nightmares about separation	Y	S	N
Physical complaints about the time of separation transition	Y	S	N
Worries about parent(s) leaving	Y	S	N
Fearfulness of new situations, people or objects	Y	S	N
Engages in repeated behaviors (counting, cleaning organizing, hand washing, etc.)	Y	S	N
Excessive worry about everyday things	Y	S	N
Fear/excessive worry about social situations	Y	S	N

Further comments about any of the above:_____
_____
_____
_____
_____

CHILD'S STRENGTHS:

In school setting:_____
_____

In social setting:_____
_____

In home setting:_____
_____

Special Interests/Hobbies:_____
_____

Authorization for Debit/Credit Card Charges

I _____ understand that Parent Arizona and Counseling Services LLC. requires to have my credit card or debit card information on file in order to receive therapy services from any therapist working for Parent Arizona and Counseling services, LLC. Below is list of services provided by Parent Arizona and Counseling Services, LLC. that may be charged to my card if the services are provided. If a different method of payment is preferred, payment will be taken care of at the time of services. If payment is not made at the time of service, the amount of the service will be charged to the credit or debit card.

1. Individual/Family Therapy (Cost is dependent upon location)
2. Unscheduled phone session ($30.00 per 15 minutes)
3. Staffings/meetings such as IEP's, communication with court personnel, etc. (billed at the same rate as an individual session or $30.00 per 15 minutes on the phone)
4. Missed appointments without 24 hour prior notification ($50.00)
5. Documents written for court or others billed at hourly rate ($100.00 minimum)
6. Copying a file for an individual or for court ($15.00 per hour).
7. Attendance at court ($1200.00 per day)

Name as it appears on the card: _____ Phone #: _____

Email Address: _____

Debit/Credit Card #: _____ Expiration Date: ____/____

CVV (CSC) # _____ (For MasterCard or Visa, it's the last three digits in the signature area on the back of your card. For American Express, it's the four digits on the front of the card.)

Billing Address: _____
Street Address Apt #

_____
City State Zip Code

_____ _____
Signature Date

CLIENT CONSENT FOR TREATMENT FORM
Please READ and SIGN

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If I, as your counselor, need to communicate to another about your case, you must give me written permission to do so. The only exception to this is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm, or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide. Insurance companies are entitled to diagnosis, date, and type of service.

INFORMED CONSENT

Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic interventions (including out of session assignments), treatment planning, and periodic treatment plan reviews. You have the right to refuse or alter any service and intervention. While the therapist will use best effort to assist you, the nature of psychological services is that there can be no assurances of results, and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, intervention, and discussion if these seem unclear to you.

FEE RATE

The basic fee is **$110 per 50 minute in-office session** for counseling and **$135 per 70 minute in-home session.** Longer sessions are prorated from those basic fees. **10 session in-office packages are available for $1000** and**. Out-of-session phone calls** will be billed at a fee of **$30 for 15 minute increments.** If a client has pre-paid for sessions and wishes for a refund of the balance, the sessions will be prorated without the package discount and will the refund will be mailed within 5 days. Any fees that are outstanding may be sent to collections.

PAYMENT METHOD

Payment for services is expected at the time services are rendered or before. If payment is not received at the time services are rendered, the debit or credit card on file will be charged for the services. Psychological reports or court reports will not be issued until full payment for services is received.

MISSED APPOINTMENTS

If you are unable to keep an appointment, please notify me immediately by phone, email, or text (602) 492-5055. If an appointment is canceled or missed **without 24 hours prior notice, (24 hours does not include weekends) you will be billed for the late cancelled or missed in-office session at the rate of $50 and $100 for a late cancelled or missed in-home session. Third and subsequent late cancellations will be billed the full fee.**

RESPONSIBILITY

The client (or responsible party) is considered responsible for payment of professional services. When you request to bill a third party, such as a church organization, and that third party fails to make payment within 30 days from the date of billing, payment is expected from client or responsible party with 10 days of receipt of statement.

CONSENT

I, voluntarily, agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form, I acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me.

_____	_____	_____	_____
Client Signature	**Date**	**Therapist Signature**	**Date**

_____ _____

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I,_____ am the parent or legal guardian with legal custody of
(Parent/ Guardian Signature)

_____ and give permission to provide counseling services to my child(ren) identified above.