FAMILY STRATEGIES
COUNSELING CENTER

1745 S Alma School Rd., Suite 230, Mesa, AZ 85210 | Phone: 480-668-8301 | FAX 480-558-3020 | familystrategies.org

NEW CLIENT INFORMATION
(please print clearly)

CLIENT INFORMATION

Client Name: ____ DOB: _______________________ Age: _____
First *Last* *MM/DD/YYYY*

FOR MINOR CHILD ONLY:
NOTE: If parents are divorced, court custody documents must be provided prior to the first session. If parents share joint custody, both must sign the "Client Consent" form.

Parent/Legal Guardian/Father Name/Phone/Email: ____

Parent/Legal Guardian/Mother Name/Phone/Email: ____

Current school: ______________________________________ Grade: _ Please Select __________

Client Address: ____

City: ______________________________, State: ____________________ ZIP: _______________

Cell Phone: ______________________________ Home Phone: ______________________________

Which number do you prefer we use to contact you? ☑ Cell ☐ Home

Email Address: ____

☐ **Yes, I would like to receive periodic emails about Family Strategies' specialty programs and services. We DO NOT sell or provide email addresses to others.**

Gender: ☐ Male ☐ Female ☐ Other (*please clarify*) ____

Employer: ______________________________ Occupation: ______________________________

Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower ☐ Long-term relationship

Person authorized to speak to Family Strategies regarding your **scheduled appointments**: ____________________

Relationship to client: ______________________

Person authorized to speak to Family Strategies regarding your **account/financial** matters: ____________________

Relationship to client: ______________________

Client signature or representative: ______________________________ Date: ____________________
Signature of Client or Legal Guardian if client is under the age of 18

Client Name: ____ DOB: ___________________________

EMERGENCY CONTACT

Emergency Contact Name: ____
First *Last*

Relationship to you/client: ____

Phone Number of emergency contact:____

EXCHANGE of CONFIDENTIAL INFORMATION

In efforts to provide me with the best possible care, I hereby authorize my therapist to share confidential information regarding my treatment with other professional staff at Family Strategies. Permitted disclosures include, but are not limited to, discussion and sharing and/or providing access to my records as appropriate, which includes, but is not limited to, treatment plans, intake assessments and progress notes. "Professional staff" includes, but are not limited to, the Executive Team, Clinical Supervisors, therapists and interns who have expertise regarding specific clinical issues and treatment planning. I give this authorization of my own free will and have discussed any questions or concerns with my therapist. By signing this consent to exchange confidential information, I acknowledge that I have both read, understood and that I agree to all the terms of this release. I understand that my records are protected under Federal and State Confidentiality Regulations. I understand that I may revoke my consent at any time by written notice, and that my participation in Family Strategies' treatment program(s) is conditional on the above consent.

____

Signature of Client or Legal Guardian if client is under the age of 18 ***Date***

FINANCIAL RESPONSIBILITY

Client Name: ____ ☐ Check this box if you, the client, are financially responsible for yourself .

Name of responsible party: ____ Relationship: ________________________

Date of Birth: _______________________________________ Cell Phone: ____

Address: ____
City *State* *Zip*

Email Address: ____

I accept full responsibility for all fees due for professional services. I realize that any third-party billing is out of courtesy to me and does not transfer any financial responsibility for unpaid services. I understand that I will be billed for all charges until a third-party authorization is signed by the third party payor and on file with Family Strategies.

If I am using my insurance, I understand that I am responsible for any allowable amount that my plan does not cover.

If you as the client are an adult and a family member or friend is providing payment on your behalf, do you authorize Family Strategies to speak with them regarding the financial aspect of your account? ☐Yes ☐No

____

Signature of Responsible Party (Required) ***Date***

INSURANCE DETAILS

If your insurance carrier is not currently one with whom we contract, your account will be considered "Self-Pay" and will be billed accordingly

CLIENT INFORMATION

In addition to providing this information we will need to scan your insurance card and driver's license.

Client Name *(as appears on your insurance card)*: ____

Client Date of Birth: ___________________________ Gender: ▢ Male ▢ Female ▢ Other: ___________________________________
MM/DD/YYYY *please use the gender that is on file with your insurance*

Plan Administrator: ____
as shown on the card. Example: AZBLUE, Meritain, Aetna, etc

Third Party Insurance Network* ____
· **ONLY If your plan administration is through a THIRD-PARTY ADMINISTRATOR (such as Meritain, Gilsbar, HealthSmart, etc.)*

Member ID: ____
include all letters and numbers

PPO Group #: ____ Other Group #: ____

Group Name: ____ Start Date: ____

Employer: ____

PRIMARY INSURED INFORMATION

▢ CHECK THIS BOX IF THE CLIENT AND SUBSCRIBER ARE THE SAME PERSON. *(skip to Financial Responsibility)*

Subscriber's Name *(as appears on your insurance card)*: ____

Subscriber Date of Birth: ___________________________ Gender: ▢ Male ▢ Female ▢ Other: ________________________________
MM/DD/YYYY *please clarify*

Relationship to Client: ____

Client Name: ____ DOB: ________________________

AUTHORIZATION for DEBIT/CREDIT CARD CHARGES

Having a valid credit/debit card on file to use for your sessions **is required** *and will enable us to expedite your check in time and reduce overhead allowing us to keep fees as low as possible.*

By my signature below, I authorize FAMILY STRATEGIES COUNSELING CENTER (Floyd Godfrey, PhD) to debit/charge the account number I have specified below:

- At the time of check-in
- The day of my telehealth appointment
- For missed (No Show) appointments
- For late cancellations. (Late cancellations are defined as cancellations within 24 hours prior to my appointment.)

For VIDEO SESSIONS or AFTER HOURS SESSIONS: The card on file will be charged by the end of the same business day as your appointment.

GROUP THERAPY: If you join a group, the credit card on file will be charged for group fees as well ***unless you notify us otherwise.***

ONE WEEK'S WRITTEN NOTICE IS REQUIRED TO CANCEL THIS AUTHORIZATION

CREDIT CARD INFORMATION

Please check box: ☐ VISA ☐ MasterCard ☐ Discover Card ☐ Amex

NAME: ____
As it appears on the card

Credit Card #: ____

Expiration Date: ______________________________ CVV#: ________________________

Billing Zip Code: ______________________________ **IS THIS AN HSA/FSA CARD? ☐ Yes ☐ No**

____
Cardholder Signature *Date*

Client Name: ______________________________ DOB: ____________________

ADDITIONAL CLIENT INFORMATION

Therapist you are schedule to see: ______________________________

How did you hear about Family Strategies:

☐Family Member ☐Friend ☐Church ☐Insurance website ☐Google search ☐Psychology Today ☐Social Media ☐Other ______________________________

For what reason are you seeking counseling today? ______________________________

____

☐Yes ☐No Do you have a history of depression?

BEHAVIORAL HEALTH HISTORY

☐Yes ☐No Have you ever taken medication for depression?

☐Yes ☐No Does any member of your family have a history of depression?

☐Yes ☐No Does any member of your family have a history of mental illness?

☐Yes ☐No Have you **previously** received help through counseling?

If yes, who was your therapist? ______________________________

☐Yes ☐No Are you **currently** working with another therapist?

If yes, what is this therapist's name? ______________________________

Do you authorize Family Strategies to communicate with this therapist? ☐Yes ☐No, I do *NOT* authorize

Client signature: ______________________________

Signature of Client or Legal Guardian if client is under the age of 18

HEALTH HABITS

☐Yes ☐No Do you drink alcohol? If yes, how much alcohol? ____________ Per Month ____________/day/week/month

☐Yes ☐No Do you vape/smoke cigarettes? If yes, how often and how long? ____________/day ____________ # years

☐Yes ☐No Do you have a history of substance abuse?

☐Yes ☐No Are you addicted to or abuse legal or illegal drugs?

☐Yes ☐No Do you drink caffeinated beverages? If yes, how much and how often? ____________/day

☐Yes ☐No Do you have problems with eating or your appetite?

☐Yes ☐No Do you exercise regularly?

☐Yes ☐No Do you feel comfortable with your weight?

☐Yes ☐No Do you have trouble sleeping?

☐Yes ☐No Have you ever had a seizure?

☐Yes ☐No Do you have a history of head injuries or concussions? If yes, when ______________________________

MEDICAL CARE HISTORY

☐Yes ☐No Do you have a Primary Care Physician?

PCP Name: ______________________________ Phone: ____________________

What is the date of your last physical exam? ______________________________

Do you authorize Family Strategies to communicate with your PCP? ☐Yes ☐No, I do *NOT* authorize

Client signature: ______________________________

Signature of Client or Legal Guardian if client is under the age of 18

OVERVIEW OF MEDICAL HISTORY *(CONTINUED)*

Please list any hospitalizations in the last year: ____

Have you had, or do you currently have, any symptoms or problems in any of the following areas to a significant degree:

☐ Chest/heart ☐ Head/Brain Injury ☐ Neck ☐ Intestinal ☐ Kidneys
☐ Lungs/Respiratory ☐ Ear/Nose/Throat ☐ Back ☐ Skin ☐ Reproductive
☐ Bladder ☐ Bowel ☐ Other: ____

Please, briefly describe your symptoms: ____
____

Have you had, or do you currently have, any medical conditions or diseases? Please list:
____
____

Please list the medical conditions your parents, grandparents or siblings have had or currently have and indicate which family member:
____
____

Please list any medications you currently take **and** the condition for which you take them:

Medication: ____ Taken for: ____
Medication: ____ Taken for: ____
Medication: ____ Taken for: ____
Medication: ____ Taken for: ____
Medication: ____ Taken for: ____

Please list any medications you are allergic to: ____

Do you currently have an infectious disease? ☐ Yes ☐ No

This is a self-report – Please note any that apply: ☐ Strep ☐ Lice ☐ HIV ☐ STD ☐ Chicken Pox ☐ Measles, Mumps, Rubella
☐ Bed Bugs ☐ Other *(please list)*: ____

Do you have a learning disability? ☐ ADHD ☐ APD ☐ Dyscalculia ☐ Dyspraxia ☐ Dysgraphia ☐ Dyslexia ☐ LPD
☐ Memory ☐ Language Processing Disorder ☐ Non-Verbal Learning ☐ Visual Perception/Visual Motor Deficit
☐ Other *(please list)*: ____

CHILD/ADOLESCENT HEALTH HISTORY *(only if client is under the age of 18)*

Who lives in the home? (name, age, relationship to client) ____
____
____

☐ Yes ☐ No Are there pets in the home? If yes, what type? ____

PRENATAL HISTORY *(biological mother of minor client listed on page 1)*:

During Pregnancy

☐ Yes ☐ No Medical Conditions Describe: ____
☐ Yes ☐ No Emotionally Stressful Describe: ____
☐ Yes ☐ No Tobacco/Cigarette Use Describe: ____
☐ Yes ☐ No Alcohol Use Describe: ____
☐ Yes ☐ No Substance/Drug Abuse Describe: ____

CHILD/ADOLESCENT HEALTH HISTORY *(only if client is under the age of 18) (CONTINUED)*

Birth

☐ Yes	☐ No	Premature	Describe: ____________
☐ Yes	☐ No	Full Term	Describe: ____________
☐ Yes	☐ No	Vaginal Delivery	Describe: ____________
☐ Yes	☐ No	C-Section	Describe: ____________
☐ Yes	☐ No	Birth Weight Issues	Describe: ____________
☐ Yes	☐ No	Birth Injury	Describe: ____________
☐ Yes	☐ No	Oxygen after Delivery	Describe: ____________
☐ Yes	☑ No	Admit to NICU	Describe: ____________
☑ Yes	☐ No	Infection	Describe: ____________
☐ Yes	☐ No	Jaundice	Describe: ____________
☐ Yes	☐ No	Seizures	Describe: ____________
☐ Yes	☐ No	Birth Defects	Describe: ____________
☐ Yes	☐ No	Feeding Problems	Describe: ____________
☐ Yes	☐ No	Postpartum Depression	Describe: ____________
☐ Yes	☐ No	Other	Describe: ____________

____
____
____
____

To reschedule or cancel an appointment, please call our Client Care Specialists at 480-668-8301
To reach our Billing Department, including questions about insurance, please call 480-668-8301, x 1300.
To reach the Office Manager, please call 480-668-8301, x 1002.

We look forward to serving your behavioral health needs.

If you need immediate or emergency mental health care, please call the

Behavioral Health Crisis Line at 602-222-9444*.*
THIS NUMBER IS NOT ASSOCIATED WITH FAMILY STRATEGIES COUNSELING CENTER.

FAMILY STRATEGIES
COUNSELING CENTER

CLIENT INFORMATION and INFORMED CONSENT

Please read ALL information carefully and thoroughly and initial where indicated.

NOTE: If you are seeing a therapist at Family Strategies for couples therapy, each person must fill out a SEPARATE set of forms for your first couples session.

WELCOME

It takes courage to reach out for support and we look forward to supporting your healing journey. These forms contain information about Family Strategies' professional counseling services and business policies. It is important that you review the following information before beginning your first session. Please feel free to ask any questions you may have about these policies; we are happy to discuss them with you. There are multiple places where your signature will be required on the following forms.

THERAPY SERVICES - RISKS and BENEFITS

_____ (*initial*) The role of a licensed counselor is to assist you with challenges that may impact you emotionally. Counseling often involves discussing difficult aspects of your life. During our work together you may experience uncomfortable feelings such as sadness, guilt, shame, anger, or frustration. As a result of what comes out of your therapeutic work and the decisions you make, important relationships may be impacted or may end. Your journey in therapy may also lead to healthier relationships. If you ever have concerns about your therapy process, I encourage you to discuss this with your therapist during your sessions so that we can collaborate together as you move forward.

TERMINATION of THERAPY

_____ (*initial*) You may terminate therapy at any point. When our work comes to an end, we ask that you schedule at least one final session in order to review the work you have done. Occasionally clients return to therapy to process new challenges. If you decide to return in the future, please know that we have an open-door policy and we welcome the possibility of working together again. However, it will be at our clinical discretion and also dependent on your therapist's availability. There can be a wait of up to 2-4 weeks. If your therapist is unable to see you immediately, we will be happy to add you to the waiting list or provide you with a referral to another competent therapist(s).

Your therapy records are closely protected and maintained for six (6) years after the last date of treatment. If you would like to obtain a copy of your treatment records, you can do so by sending a written request directly to your therapist at our office.

LENGTH of THERAPY

_____ (*initial*) Therapy is a process that is unique to each client and the challenges they are experiencing. Some issues can be worked on very effectively in a short period of time, and other challenges may take much longer. It can be difficult to predict exactly how long therapy will last so this is best discussed in your first session. You and your therapist will put together a treatment plan and goals that you will be working toward. If you have questions regarding the length of treatment, please feel free to discuss this with your therapist at the start and/or at any point during therapy.

DUAL THERAPY

_____ (*initial*) It is unhelpful for two different therapists to provide counseling for the same client at the same time. Unless there is a compelling clinical reason, a crisis, or a specialized therapy treatment plan that we will be working on, we do not work with clients who are under the care of another therapist outside of Family Strategies. If you are working with another therapist outside our office, please disclose this so that you can discuss the next steps with your Family Strategies therapist. If your therapist has referred you to Family Strategies for specialized treatment (i.e. sex addiction, sex therapy, etc.), we will need to have a release on file from you in order to coordinate care with your primary therapist and collaborate on a clinical plan that best supports your process.

CLIENT INFORMATION and INFORMED CONSENT *(continued)*

CONJOINT SESSIONS

_____ (*initial*) On occasion, and only if it benefits the client's therapy goals, your therapist may invite you to ask a family member or significant other to join you for a therapy session. It is important to note that this is done only on occasion and at your therapist's clinical discretion when it best serves the client. If the person joining the session is your significant other, this does not constitute as couple's therapy, rather it is as a support to your work, and/or a check-in session. Additionally, the third party (friend or significant other) is not joining the session for his or her own therapy, nor will your therapist work with them as a therapist.

NO SECRETS POLICY

_____ (*initial*) Please note that with couples therapy the couple is the client (e.g. the treatment unit), not the individual. As such we practice a "no secrets" policy when conducting marital/couples' therapy. This means that confidentiality does not apply between the couple when one member of the treatment unit requests an individual session or contacts the couple's therapist outside of the therapy session to share a secret. Secrets do not include personal thoughts, feelings, desires, etc. of one of the parties, rather information that would be painful, harmful, or betraying to the other partner (i.e. affairs, financial betrayal, etc.). On occasion an individual session may be scheduled to assist in the overall therapy process to the treatment unit (e.g. the couple) and will be scheduled only when mutually agreed upon. Please understand that the majority of information shared in the individual sessions will not be held in confidence or secret in the couple's sessions. Your therapist will encourage the person holding the secret to share the secret in the following session and will support the client in doing so. Your therapist also reserves the right to share or disclose information revealed by one partner in an individual session to the other partner or family members as deemed appropriate or necessary to support the treatment unit's overall treatment progress and goals.

SOBRIETY POLICY

_____ (*initial*) Family Strategies asks that all clients, couples, families, and group members arrive at therapy sober and not under the influence of drugs and/or alcohol. If any member of our staff notices that you are intoxicated or substance impaired, the therapy session will be immediately terminated. Once you are safely home, you may reschedule the therapy session. You will be charged your full fee for the session if you arrive intoxicated or impaired.

PHYSICAL CONTACT

_____ (*initial*) Sexual contact is never acceptable in the therapeutic relationship. In some cultures, a supportive hug or other physical contact can be an expression of affection, or a greeting, or a goodbye. However, supportive physical contact can also be misconstrued, triggering, or may interfere with the therapeutic relationship. As a general policy our therapists do not offer supportive physical contact of any kind within the therapeutic relationship. Please understand, this is not an expression of judgment, dislike or dismissal, rather it is in the best interest of your clinical care based on a professional and therapeutic boundary. You always have the right to refuse physical contact at any time or for any reason.

CONFIDENTIALITY

_____ (*initial*) Therapy is best experienced in an atmosphere of trust. Thus, all therapy services are strictly confidential and may not be revealed to anyone without your written permission. **There are exceptions to confidentiality where disclosure is required by law (see below).** Your confidentiality is very important to us. Should you request that your therapist speak with another professional or person (i.e. doctors, former therapists, teachers, family, friends or anyone else outside the therapy room), you must first provide your signed written consent in order to do so and only after your therapist determines if this is in the best interest of supporting your therapeutic process and progress. There are times when consulting with adjunct clinicians can be very helpful in providing you with the best possible care. As a member of the therapeutic team at Family Strategies, your therapist has a unique opportunity to utilize the vast experience and expertise of other clinicians.

In an effort to provide me with the best possible care, I hereby authorize my therapist to exchange confidential information regarding my treatment to other professional clinical staff at Family Strategies, LLC. Professional staff includes, but are not limited to, the Executive Directors, Clinical Supervisors, and other therapists who have expertise regarding specific clinical issues and treatment planning. I give this authorization of my own free will and have discussed any questions or concerns with my therapist. By signing this consent to exchange confidential information, I acknowledge that I have both read, understood and that I agree to all the terms of this release. I understand that my records are protected under Federal and State Confidentiality Regulations.

____

Client's Signature *Signature of Client or Legal Guardian if client is under the age of 18* *Date*

CLIENT INFORMATION and INFORMED CONSENT *(continued)*

LEGAL EXCEPTIONS to CONFIDENTIALITY

_____ (*initial*) Your information is always confidential with the exception of information relating to child abuse, suspected child abuse, elder abuse, dependent adult abuse, or intent to harm self or others, or unless mandated by a court of law. Legally, therapists are mandated reporters of abuse or intent to harm another. If you are suicidal or homicidal your therapist at Family Strategies will take all reasonable steps to prevent harm to you or another.

A minor is defined as any person who is legally under the age of 18. Wether your therapist works with minors or not, they are mandated reporters of any sexual acts involving minors. This means that if any therapist or staff at Family Strategies learns of any incident involving minors and illegal sexual activity, or other types of abuse or neglect, they are legally required to report this to the proper authorities.

I understand the above stated limits of confidentiality and mandated reporting responsibilities of my therapist and Family Strategies.

____

Client's Signature *Signature of Client or Legal Guardian if client is under the age of 18* *Date*

COURT REPORTS or LETTERS, COURT HEARINGS

_____ (*initial*) The therapists at Family Strategies do not write legal letters or court reports on behalf of clients involving divorce, custody or other legal matters or lawsuits. We do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc.) or agency regarding your treatment. If a special circumstance arrives where a letter is required by court order, it will require your written consent and will be billed to you at $25.00 per page and in addition to your therapist's hourly fee.

As a general policy the therapists at Family Strategies are not forensic specialists and prefer to not testify or participate in court proceedings on behalf of a client as that has the potential of changing the overall purpose and scope of our services. If you become involved in legal proceedings that require mandated participation by your therapist, you will be expected to pay for all of your therapist's professional time including preparation and transportation time and costs, even if called to testify by another party regarding your case. Because of the time involved and the interruption to your therapist's clinical work and compensation, you will be charged $350.00 per hour for preparation, travel, and attendance at any legal proceeding on your behalf. A detailed accounting of time is available to you upon request.

Court fees can be very expensive. Please sign and date below to indicate that you understand your financial responsibility in covering these expenses should we be mandated to go to court for a legal issue you are involved in. Your therapist is not a court advocate or friend. A therapist must legally speak truthfully under oath.

____

Client's Signature *Signature of Client or Legal Guardian if client is under the age of 18* *Date*

THERAPY SESSIONS and FEES

_____ (*initial*) The fee for a standard therapy session at Family Strategies varies by therapist. The standard therapy session is 45 - 55 minutes in length. Therapy can be conducted in person in the office, via phone, or videoconference. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past your allotted time, nor will the time be made up at future sessions. Therapy sessions are paid via credit card, check, or cash. Please fill out the credit card form included in this packet and bring with you to your first session. If paying with cash, please bring the exact cash amount for your session fee as Family Strategies does not normally keep cash on premises.

Fees are reviewed annually and may increase periodically. The increase will be discussed with the client, and a 30-day notice will be posted prior to the increase. Your therapist is happy to answer any questions you may have about this fee agreement. Please understand that you have the right to terminate therapy at any point. If you have any questions regarding the fee policy, please do not sign until discussing with your therapist.

CLIENT INFORMATION and INFORMED CONSENT *(continued)*

APPOINTMENTS and CANCELLATIONS

_____ (*initial*) Appointment cancellations made less than 24 hours before the scheduled appointment will be charged the full agreed upon fee for the session. If you do not show up for a scheduled appointment (that you have not called to cancel within 24 hours) you will be charged the full fee for the session. You are responsible for keeping track of and attending your sessions. *If you are sick or experiencing any symptoms of illness, please call the office ahead of your appointment and ask to conduct your session via the phone or videoconference. If your therapist is ill, the same consideration will be extended to you.*

THERAPIST AVAILABILITY BETWEEN SESSIONS

_____ (*initial*) Your therapist may be available to answer a short email regarding your therapy appointment times or therapy homework no more than twice per month without charging a fee. We will not process therapy issues via email unless you have been specifically instructed to do so as part of your treatment. If therapeutic services are required during non-business hours you will be charged 25% of your therapist's rate for every 15 minutes.

E-THERAPY - i.e. TELEMEDICINE, TELETHERAPY, CYBERTHERAPY, etc. (when applicable)

_____ (*initial*) E-therapy is the use of electronic media and information technologies to provide mental health services in different locations. There are limitations and risks associated with e-therapy, including inherent confidentiality risks of electronic communication and potential for technology failure. If there is an emergency and the therapist is unavailable, you should call 9-1-1. If video is not available, the therapist will ask for identification. You will also be asked about your physical location during the telemedicine encounter, as well as verification that the setting provides for your confidentiality.

Family Strategies does not allow either the counselor or client to record any portion of video or telephonic therapy sessions unless prior consent has been obtained in writing for the purpose of training or supervision.

By signing below, you recognize that if there is an emergency and your therapist is unavailable, you should call 9-1-1. You also acknowledge that if video is not available, your therapist will ask for identification. You will be asked to provide your therapist with your physical location during the encounter, and verification that your setting provides for your confidentiality.

____

Client's Signature *Signature of Client or Legal Guardian if client is under the age of 18* *Date*

THERAPEUTIC APPROACH and STYLE

_____ (*initial*) Our goal at Family Strategies is to help people navigate through difficulties in their life and relationships while providing a safe place to heal, explore, develop insight, practice healthy coping tools, and integrate and take responsibility for their changes. Our therapeutic approach is collaborative, honest, challenging, and direct with solid boundaries and empathy. We use a variety of client-centered modalities with clients.Your therapist may reflect, assist, encourage, and point out incongruent patterns around actions and words. Your therapist will formulate the therapeutic plan collaboratively with you based on your needs, presenting problems, and the goals you wish to achieve. At Family Strategies, we believe that each client has the potential for healing and change, is responsible for their choices and changes, and for meeting their therapy goals – *we do not make guarantees for healing.*

INFORMED CONSENT

_____ (*initial*) Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. Therapy 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 intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While your therapist will use their best effort to assist you, there can be no assurances of results, and no promises can be made regarding the outcome of any service provided. You should question the rationale of any service, intervention, and discussion if these seem unclear to you. Your signature below indicates that you understand that there are risks for noncompliance with treatment recommendations, and that you will discuss these risks with your therapist.

CLIENT INFORMATION and INFORMED CONSENT *(continued)*

GROUP THERAPY

_____ (*initial*) Due to the nature of group therapy, neither Family Strategies nor its therapists may release group records without compromising the confidentiality of other participants, which is prohibited by Arizona law. All group records are stored "together" on a single form, which makes individual notes for the group unavailable for copy and release. If you, as a client, require group records for any legal reason, you (or your health care decision maker) must make such a request in writing, and Family Strategies and its therapists are restricted to supplying only dates of service and general topics reviewed during classes and group sessions.

CLINICAL SUPERVISION

_____ (*initial*) Your therapist _________________________________ is under clinical supervision as an associate licensed counselor with the Arizona Board of Behavioral Health, or is a university intern studying for a master's degree, and provides therapy under the clinical supervision of Dr. Kim Buck, LPC, John Hinson, LPC, Abbie Ashton, LMFT, Angie Hatch, LPC, John McLean, LPC, Nick Miller, LPC, and/or Julie Young, LPC, who are qualified to provide supervision within the state of Arizona according to the laws and regulations set forth by the Arizona Board of Behavioral Health. You can contact any of the above-mentioned supervisors by calling 480-668-8301.

FINANCIAL RESPONSIBILITY

_____ (*initial*) You (or responsible party) are considered responsible for payment of professional services. When you request to bill a third party, such as an insurance company, and that third party fails to make payment within 30 days from the date of billing, the client or responsible party is expected to pay within 10 days of receipt of the statement. Bills not paid within 30 days from the date of billing will be subject to an interest charge of 10% of the outstanding bill.

ROI CONSENT

_____ (*initial*) In an effort to provide me with the best possible care, I hereby authorize my therapist to exchange confidential information regarding my treatment to other professional clinical staff at Family Strategies for the purpose of training, my own therapeutic benefit, and coordination of my care. Professional staff includes, but are not limited to, the Executive Team, Supervisors, therapists and interns who have expertise regarding specific clinical issues and treatment planning. If at any time it would be advantageous for these individuals to participate in my treatment or visit sessions, I will give verbal consent for this to occur. I give this authorization of my own free will and have discussed any questions or concerns with my therapist. By signing this consent to exchange confidential information, I acknowledge that I have both read, understood and that I agree to all the terms of this release. I understand that my records are protected under Federal and State Confidentiality Regulations. I understand that I may revoke my consent at any time by written notice, and that my participation in Family Strategies' treatment program(s) is conditional on the above consent.

INFORMED 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, understood and that I agree to 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. I also acknowledge that I have received a copy of **"Client Rights"** and **"Complaint/Grievance Procedures"** as well as the **"Notice of Privacy Policies – HIPAA"** documents.

____

Client Signature *Signature of Client or Legal Guardian if client is under the age of 18* *Date*

____

Printed Name of Client

____

Therapist Signature *Date*

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I, ____ (*print name of legal guardian*) am the parent or legal guardian with legal custody of ____ *(print name of client)* **and** give permission to FAMILY STRATEGIES to provide counseling services for my child.

NOTE: If parents are divorced, and the above parent has full legal custody, court custody documents must be provided prior to the first session. If parents share joint custody, both parents MUST SIGN the "Client Consent" form.

____

Signature of parent/legal guardian *Date*

Client Name: ____ DOB: ___________________________

FAMILY STRATEGIES
COUNSELING CENTER

TELEHEALTH CONSENT FORM

This consent form is to be completed by clients seeking services exclusively via electronic Telehealth.

I, _______________________________ (client) hereby consent to engage in Telehealth with _________________________________ (therapist).

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a client's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Client Consent form I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.
3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that Family Strategies does not allow either the counselor or client to record any portion of video or telephonic therapy sessions unless prior consent has been obtained in writing for the purpose of training or supervision.
9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the client's responsibility (e.g. co-payments)].
10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.
11. I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

[For conjoint or family therapy, clients may sign individual consent forms or sign the same form.]

____

Client's Signature ***Date***

____

Client's Printed Name

Verbal Consent Obtained: Therapist reviewed Telehealth Consent Form with Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

____

Therapist's Signature ***Date***

CLIENT RIGHTS

CLIENT: ***The following pages are to be downloaded for your information. Please print a copy for your record and be prepared to confirm at your first appointment that you have read and understood the information.***

Arizona Statutes R9-10-1907, Office of Medical Licensing, requires that at the time of your initial appointment you be informed of your rights as a client and, if applicable, the client's parent, guardian, custodian, designated representative, or agent receive a copy of this document.

All clients shall be afforded the following basic rights:

1. The right to be treated with dignity, respect, and consideration;
2. The right to **not** be subjected to:
   a. Abuse
   b. Neglect
   c. Exploitation
   d. Coercion
   e. Manipulation
   f. Sexual abuse
   g. Sexual assault
   h. Restraint or seclusion
   i. Retaliation for submitting a complaint to the Department or another entity
   j. Misappropriation of personal and private property by a counseling facility's personnel member, employee, volunteer, or student.
3. A patient, or the patient's representative, has the right to:
   a. Either consent to or refuses counseling
   b. Refuse or withdraw consent for receiving counseling before counseling is initiated
   c. Is informed of the following:
      i. The counseling facility's policy on health care directives
      ii. The patient complaint process
   d. Consent to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a counseling facility for identification and administrative purposes
   e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      i. Medical record
      ii. Financial records.
4. The right to **not** to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
5. The right to receive counseling that supports and respects the patient's individuality, choices, strengths, and abilities;
6. The right to receive privacy during counseling;
7. The right to review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
8. The right to receive a referral to another health care institution if the counseling facility is not authorized or not able to provide the behavioral health services needed by the patient;
9. The right to participate, or have the patient's representative participate, in the development of, or decisions concerning, the counseling provided to the patient;
10. The right to participate or refuse to participate in research or experimental treatment; and
11. The right to receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.
12. The right to review, upon written request, the client's own record during the agency's hours of operation or a time agreed upon by the clinical director, except as described in R9-20-211(A)(6).
13. The right to review the following at the agency or at the "Department": the A.A.C. Title 9, Chapter 20 Rules; the report of the most recent inspection of the premises conducted by the "Department"; a plan of correction in effect as required by the "Department"; if the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the "Department", the most recent report of inspection conducted by the nationally recognized accreditation agency; and if the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the "Department", a plan of correction in effect as required by the nationally recognized accreditation agency.
14. The right to be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation.
15. The right to receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment.
16. The right to be offered or referred for the treatment specified in the client's treatment plan.
17. The right to receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan.
18. The right to give <u>general</u> consent and, if applicable, <u>informed</u> consent to treatment, refuse treatment or withdraw <u>general or informed</u> consent to treatment, unless treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. 36-512.

CLIENT RIGHTS *(continued)*

19. The right to be free from: abuse; neglect; exploitation; coercion; manipulation; retaliation for submitting a complaint to the "Department" or another entity; discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent; treatment that involves the denial of: food, the opportunity to sleep, or the opportunity to use the toilet; and restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.
20. The right to participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan.
21. The right to control the client's own finances except as provided by A.R.S. 36-507(5).
22. The right to participate, or refuse to participate, in religious activities.
23. The right to refuse to perform labor for an agency, except for housekeeping activities and activities to maintain health and personal hygiene.
24. The right to be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan.
25. The right to participate, or refuse to participate, in research or experimental treatment.
26. The right to give informed consent in writing, refuse to give informed consent, or withdraw informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or treatment that is not a professionally recognized treatment.
27. The right to refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings.
28. The right to receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility.

COMPLAINT / GRIEVANCE PROCEDURE

There is an established process for resolving client complaints at Family Strategies Counseling Center. In the event you are dissatisfied with the services you have received please:

1. Contact your counselor and advise them of your complaint. If not satisfied, contact:
2. The Office Manager of Family Strategies Counseling Center. The Office Manager will work with the Executive Team to help resolve your situation. You may make your complaint by phone, mail, or in person. Every effort will be made to call you as soon as possible that same working day. Complaints must be filed within six months of your last appointment. The complaint will be reviewed within 14 working days.
3. Once a decision is made on your complaint, you will be notified of the outcome within 30 days. If you are not satisfied, you may then contact:

ARIZONA DEPARTMENT OF HEALTH SERVICES

Office of Medical Licensing
150 North 18th Avenue, Suite #410
Phoenix, AZ 85007
(602) 364-2595
Division of Behavioral Health Services

150 North 18th Avenue, Suite #200
Phoenix, AZ 85007
(602) 364-4585

All Family Strategies Counseling Center Policies and Procedures, and documented reports are available for review upon request by appointment by calling (480) 668-8301.

BEHAVIORAL OFFICE OF HUMAN RIGHTS ADVOCATES

Health Licensing Health Services
150 N. 18th Ave., 2nd Floor
Phoenix, AZ 85007
(602) 364-4585

Arizona DES Child Protective Services
P.O. Box 44240
Phoenix, AZ 85064-4240
(888) 767-2445

Arizona DES Adult Protective Services
1789 W. Jefferson St
Phoenix, AZ 85007

(877) 767-2385

Arizona Center for Disability Law
5025 E. Washington St, Suite 202
Phoenix, AZ85034
(602) 274-6287

Regional Behavioral Health Authority:
Magellan Health Services of Arizona (Maricopa County)
4801 E. Washington St., Suite 100
Phoenix, AZ 85034
(800) 564-5465

FAMILY STRATEGIES
COUNSELING CENTER

NOTICE OF PRIVACY POLICY - HIPAA

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. PROTECTED HEALTH INFORMATION (PHI): Family Strategies understands the importance of protecting health information about our clients. Our practice creates records of care and services provided by therapists. These records are to provide our clients with quality care as well as to comply with certain legal requirements. This notice is to inform you of the ways in which we may use and disclose health information about you as well as to inform you of legal obligations to disclose. Your clinician is required by law to:

1. Make sure that Protected Health Information ("PHI") that identifies you is kept private.
2. Give you this notice of legal duties and privacy practices with respect to health information.
3. Follow the terms of the notice that is currently in effect.
4. Family Strategies can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request.

II. HOW FAMILY STRATEGIES MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose health information.

1. For Treatment, Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. This includes coordination with third party providers for referrals and consultations from one health care provider to another.
2. Family Strategies as an agency requires monthly staffing with clinicians. Your protected health information may be used in coordination of staffing within the agency to provide quality care.
3. Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. Family Strategies maintains "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
    a. For use in treating you.
    b. For use in defending Family Strategies/Clinicians in legal proceedings instituted by you.
    c. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
    d. Required by law and the use or disclosure is limited to the requirements of such law.
    e. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. Family Strategies will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. Family Strategies will not sell your PHI in the regular course of my business.
4. Even if you do have a signed authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures not needed of your PHI.

NOTICE OF PRIVACY POLICY – HIPAA *(continued)*

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION: Subject to certain limitations in the law, Family Strategies can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law and the use or disclosure complies with, and is limited to, the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although the first priority is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on our premises.
6. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with me. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT: Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask not to use or disclose certain PHI for treatment, payment, or health care operations purposes.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way or to send mail to a different address, and we will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request the correction of the existing information or add the missing information.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.

VII. FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS WERE VIOLATED:

1. You can complain if you feel we have violated your rights by contacting us at Family Strategies Counseling Center: 1745 South Alma School Rd, Mesa, AZ 85210, calling (480) 668-8301, or emailing at admin@familystrategies.org.
2. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1- 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be retaliated against for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE: *This notice went into effect on March 11, 2020.*