

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: _____

Gender: Male Female Other: (please clarify) _____

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: _____

Client Address: _____

City: _____, State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

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.

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's Signature

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

Date

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.

Client's Signature

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.

Yes No

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?

Client's Signature

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

Date

Client Name: _____ DOB: _____

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: _____

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

ADDITIONAL CLIENT INFORMATION

Therapist you are scheduled 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?

HEALTH HABITS

Yes No Do you drink alcohol?
If yes, how much alcohol? _____ **Day / Week / Month**
(please circle frequency)

Yes No Do you vape/smoke cigarettes?
If yes, how frequently? _____ **/Per Day**
For how long? _____

Yes No Do you have a history of substance abuse?
 Yes No Are you addicted to or abuse legal *or* illegal drugs? *Including marijuana*
 Yes No Do you drink caffeinated beverages?
If yes, how much & how often? _____ **Day / Week / Month**
(please circle frequency)

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 exam? _____

Yes No Do you authorize Family Strategies to communicate with your PCP?

Please list any hospitalizations in the last year: _____

Have you had, or do you 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
- Back Ear/Nose/Throat Skin Bladder Bowel Reproductive
- Other: _____

Please, briefly describe your symptoms: _____

ADDITIONAL CLIENT INFORMATION (continued)

MEDICAL CARE HISTORY (CONTINUED)

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

Do you have a family history of any medical conditions? Please list: *(include parents, immediate grandparents & siblings only)*

Please list any medication you currently take **and** the condition for while 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: _____

- Yes No Do you currently have an infectious disease? *This is a self-report – Please note any that apply:*
- Strep Lice HIV STD Chicken Pox Measles, Mumps, Rubella Bed Bugs
- Other *(Please list):* _____
- Yes No Do you have a learning disability? *(Please indicate below)*
- ADHD APD Dyscalculia Dyspraxia Dysgraphia Dyslexia LPD Memory
- Language Processing Disorder Non-Verbal Learner Visual Perception/Visual Motor Deficit
- Other *(Please list):* _____

BEHAVIORAL HEALTH HISTORY

- Yes No Do you have a history of depression?
- 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 ever seen a therapist for counseling prior to now?

If yes, who was your therapist? _____

- Yes No Are you currently working with another therapist?

If yes, who is your therapist? _____

- Yes No Do you authorize Family Strategies to communicate with your current therapist?

I certify that the information provided in this Medical and Behavioral Health History form is true, complete, and accurate to the best of my knowledge. I understand that this information will be used by my treatment providers to assist in the planning and delivery of my care. I agree to notify Family Strategies Counseling Center of any significant changes to my medical, mental health, or medication history.

Client's Signature

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

Date

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

Who lives in the home? (Include 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: _____

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.

If you see 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 seek support, and we look forward to walking with you on your healing journey. These forms outline Family Strategies' professional counseling and psychological services, along with our business policies. Please review this information before your first session. If you have any questions, we are happy to discuss them with you. You will be asked to provide your initials and signature in several places throughout the forms.

THErapy SERVICES - RISKS and BENEFITS

_____(initial) Whether working with a licensed counselor or a licensed psychologist, therapy is designed to help you address emotional and personal challenges. The process often involves discussing difficult parts of your life, which may bring up uncomfortable feelings such as sadness, guilt, shame, anger, or frustration. At times, the insights you gain and the choices you make in therapy may affect important relationships—some may improve while others may change or even end. Your therapeutic journey can also lead to greater self-awareness and healthier connections. If you ever have concerns about your therapy experience, please bring them up with your therapist so you can work together to address them as you move forward.

THERAPEUTIC APPROACH and STYLE

_____(initial) At Family Strategies, our goal is to help you navigate life and relationship challenges in a safe space where you can heal, gain insight, and practice healthy coping tools. Our licensed counselors and psychologists provide a collaborative, honest, and empathetic therapeutic process that also offers structure, challenge, and clear boundaries. Using client-centered approaches, your therapist will reflect, guide, and point out patterns that may be holding you back. Together, you will create a treatment plan based on your needs, concerns, and goals. We believe every client has the capacity for healing and growth, and that each individual is responsible for their choices and progress. While we cannot guarantee outcomes, we are committed to supporting your journey toward meaningful change.

DESCRIPTION OF THERAPY PROCESS

_____(initial) Therapy is a collaborative process between you and your licensed counselor or psychologist. Its purpose is to promote growth, insight, and positive change. At times the process may feel challenging, while at other times it may feel encouraging or rewarding. You are expected to take an active role in your treatment, including any suggested activities outside of sessions. You always have the right to ask questions, refuse recommendations, or request changes to any service or intervention. Together, you and your therapist will create a treatment plan based on your needs and goals. If you have questions about the length or direction of treatment, you are encouraged to discuss them at any time. While your therapist will provide support, guidance, structure, and clear boundaries, no specific results can be guaranteed. At Family Strategies, we believe every client has the capacity for healing and growth, and we are committed to supporting you in that process.

RECORDING, TRANSCRIPTION and AI DEVICES

To protect the privacy, confidentiality, and therapeutic integrity of services, audio recording, video recording, photography, screen recording, livestreaming, transcription, or any other form of recording or monitoring is strictly prohibited during therapy sessions, group sessions, consultations, or other clinical services provided by Family Strategies Counseling Center unless prior written consent has been obtained from both the provider and all participating individuals. This prohibition includes the use of artificial intelligence (AI) devices, applications, wearable technology, smart glasses, smart watches, digital assistants, transcription services, or any other technology capable of recording, storing, transmitting, analyzing, summarizing, or reproducing session content. Clients, family members, support persons, and other attendees may not create, obtain, or distribute recordings, transcripts, summaries, notes generated by AI, or other reproductions of session content without advance written authorization. For group services, recording or transcription of any kind is strictly prohibited to protect the privacy and confidentiality of all participants. Family Strategies Counseling Center will not record sessions without the client's prior written consent, except as required or permitted by law.

Client's Signature

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

Date

CLIENT INFORMATION and INFORMED CONSENT

APPOINTMENTS and CANCELLATIONS

_____(initial) Cancellations made less than 24 hours before a scheduled session will be charged the full session fee. If you do not attend a scheduled appointment and have not canceled at least 24 hours in advance, you will also be charged the full fee. You are responsible for keeping track of your scheduled sessions. If you are sick or experiencing symptoms of illness, please call before your appointment to request a phone or video session. If your counselor or psychologist is ill, the same option 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.

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.

TERMINATION of THERAPY

_____(initial) You may terminate therapy at any time. When ending therapy, we request at least one final session to review your progress and closure. Some clients later choose to return for additional support. If you decide to return, please know we welcome that possibility; however, re-engagement is at the therapist's discretion and subject to availability. There may be a 2–4 week wait. If your therapist is unavailable, we can place you on a waitlist or provide referrals to another qualified provider. Your treatment records are confidential and will be securely maintained for six (6) years following your last session. You may request a copy of your records at any time by submitting a written request directly to your therapist at our office.

CLINICAL SUPERVISION (where applicable)

_____(initial) If your therapist is an associate licensed counselor under the Arizona Board of Behavioral Health Examiners, or a university intern completing graduate training, all services provided by them are 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—each qualified to supervise according to Arizona law. Supervisors may be contacted at 480-668-8301.

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.

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.

CLIENT INFORMATION and INFORMED CONSENT

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

E-therapy uses electronic communication (video, phone, or other technologies) to provide mental health services across locations. While convenient, it has risks, including limits to confidentiality and possible technology failures. In case of an emergency and your therapist is unavailable, you should call 9-1-1 or go to your nearest emergency room. If video is not available, your licensed counselor or licensed psychologist will ask you to verify your identity. You will also be asked to provide your physical location at the start of each session and confirm that your setting allows for confidentiality. Family Strategies does not permit counselors, psychologists, or clients to record any portion of video or phone sessions unless written consent has been obtained beforehand for training or supervision purposes.

By signing below, you acknowledge these terms, including the emergency protocol, identity and location verification, and confidentiality requirements for e-therapy.

Client's Signature

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

Date

RELEASE of INFORMATION (ROI) CONSENT

In an effort to provide me with the best possible care, I authorize my licensed counselor or licensed psychologist to share confidential information about my treatment with professional clinical staff at Family Strategies for purposes of training, therapeutic benefit, and coordination of care. Professional staff may include the executive team, supervisors, therapists, and interns with relevant expertise in clinical issues and treatment planning. If it would be helpful for these professionals to participate directly in my treatment or attend a session, I will provide verbal consent at that time. I give this authorization voluntarily and have discussed any questions with my therapist. I authorize my licensed counselor or licensed psychologist at Family Strategies, LLC, to share confidential information about my treatment with other professional clinical staff as needed for my care. This may include executive directors, clinical supervisors, and other therapists or psychologists who provide expertise in clinical issues and treatment planning. I give this authorization voluntarily and have discussed any questions with my therapist.

By signing, I acknowledge that I have read, understood, and agree to the terms of this release. I also understand that my records are protected under federal and state confidentiality laws and regulations.

Client's Signature

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

Date

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.

NO SECRETS POLICY

_____(initial) Please note that with couples therapy the couple is considered the client (i.e., the treatment unit), not the individual. We follow a "no secrets" policy in marital/couples therapy. This means confidentiality does not apply between partners if one member shares information privately with the therapist that is harmful, betraying, or damaging to the other (e.g., affairs, financial betrayal). Personal thoughts, feelings, and desires are not considered secrets in this context. At times, an individual session may be scheduled to support the couple's overall progress, but only with mutual agreement. Information shared in such sessions will generally not be kept confidential from the other partner. The therapist will encourage disclosure of any significant secret in the next session and will provide support in that process. The therapist also reserves the right to disclose information shared in an individual session if necessary to support the couple's treatment goals.

CLIENT INFORMATION and INFORMED CONSENT

CONJOINT SESSIONS

_____(initial) On occasion, and only when it supports your therapeutic goals, your therapist may invite you to include a family member or significant other in a session. This is at your therapist’s clinical discretion and is not a substitute for couple’s or individual therapy for the guest. If a significant other attends, the purpose is solely to support your work or serve as a check-in, not to establish ongoing therapy for them.

GROUP THERAPY

_____(initial) Due to the nature of group therapy, Family Strategies and its licensed counselors/psychologists cannot release group records without breaching the confidentiality of other participants, which is prohibited by Arizona law. Because group notes are kept on a single form, individual records are not available for copy or release. If you require group records for legal purposes, you (or your health care decision maker) must submit a written request. In such cases, Family Strategies may only provide dates of service and general topics covered in classes or group sessions.

COURT REPORTS or LETTERS, COURT HEARINGS

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

CONFIDENTIALITY

Therapy is most effective in an atmosphere of trust. All services provided by licensed counselors and licensed psychologists are strictly confidential and will not be disclosed without your written consent, except as required by law (see exceptions in following section). If you wish your therapist to communicate with another professional or individual (e.g., physician, former therapist, teacher, or family member), you must provide signed written authorization, and your therapist will determine whether such communication supports your therapeutic process. At times, consultation with other clinicians may be used to enhance your care. As part of the Family Strategies team, your therapist may draw upon the collective expertise of our clinicians to provide you with the best possible treatment.

By signing, I acknowledge that I have read, understood, and agreed to this release. I understand my records are protected under Federal and State Confidentiality Regulations. I may revoke this consent at any time through written notice. I also understand that my participation in Family Strategies’ treatment program(s) is conditional on this consent.

Client’s Signature

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

Date

CLIENT INFORMATION and INFORMED CONSENT

LEGAL EXCEPTIONS to CONFIDENTIALITY

Your information is kept confidential except in situations involving child abuse, suspected child abuse, elder abuse, dependent adult abuse, intent to harm yourself or others, or when disclosure is required by law (such as a court order). By law, all licensed counselors and psychologists are mandated reporters. This means that if you are suicidal or homicidal, your therapist at Family Strategies will take all reasonable steps to prevent harm. A minor is legally defined as anyone under 18 years of age. Regardless of whether your therapist works with minors, all Family Strategies therapists and staff are mandated reporters of abuse, neglect, or illegal sexual activity involving minors. Any such information must be reported to the appropriate authorities.

I understand the limits of confidentiality and the 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

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.

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.

BILLING as a FACILITY and PROVIDER

_____(initial) Family Strategies Counseling Center is licensed with the Department of Health Services, Medical Licensing Division. Similar to a hospital, we bill insurance for both facility and provider costs, which may result in two Explanation of Benefits (EOBs). One EOB may show provider services under the name of a licensed supervisor from our agency. This happens because our "board" of supervisors—made up of licensed counselors and licensed psychologists—oversees the clinical work of all therapists. Clients, however, are only responsible for copays and deductibles tied to facility fees for the services received.

INSURANCE BILLING

_____(initial) Family Strategies accepts select in-network insurance plans and can bill them on your behalf. Clients are responsible for knowing their insurance benefits and coverage.

As a DHS-licensed facility (Medical Licensing Division), we bill insurance for both facility and provider fees, similar to a hospital. This may result in multiple Explanation of Benefits (EOBs). You might see:

- An EOB listing a supervisor's name - this is normal. Our clinical supervisors oversee all therapists, and any of their names may appear.
- An EOB for provider fees — however, you are only responsible for the copay or deductible assigned to the facility fees.

If your insurance is **out-of-network**, you may download a statement from our patient portal and submit it to your insurance for reimbursement.

CLIENT INFORMATION and INFORMED 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's 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

Please select the option that best describes your family situation:

- The child's parents/legal guardians are together and share legal decision-making authority.
- The child's parents/legal guardians are separated, divorced, or were never married and share legal decision-making authority.
- I have sole legal decision-making authority for the child.
- I am the child's only legal parent.
- I am the child's court-appointed legal guardian.
- Other: _____

Documentation

If you have sole legal decision-making authority or are a court-appointed guardian, Family Strategies Counseling Center requires supporting legal documentation prior to the start of treatment.

NOTE: When two legal parents/guardians share legal decision-making authority, Family Strategies require consent from both parents prior to treatment.

I, _____ (*print name of legal guardian*) am the parent or legal guardian
of _____ (*print name of client*) and I am authorized to consent to
mental health treatment for this child. **and** give permission to FAMILY STRATEGIES COUNSELING
CENTER to provide counseling services for my child.

Signature of Parent or legal guardian

Date

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

FAMILY STRATEGIES

COUNSELING CENTER

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** 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 general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed 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

(877) 767-2385

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

Arizona Center for Disability Law
5025 E. Washington St, Suite 202
Phoenix, AZ 85034
(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

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.*