Please Print

Date of First Appointment with Counselor: _____ Today's Date: _____

Name of Client: _____ Date of Birth: _____
Last First

Name of Client: _____ Date of Birth: _____
(Spouse or Child Being Seen with You Today) Last First

Ethnic Background: ☐ Asian ☐ African Am ☐ Caucasian ☐ Hispanic ☐ Native Am ☐ Other _____

Parent or Guardian (If Applicable): _____

Address: _____
PO Box or Street City State Zip

Phone#: Home_____ Work_____ Cell_____

May we call you at home? ' Yes ☐ No May we call you at work? Yes ☐ No May we call your cell? Yes ☐ No

E-Mail Address: _____

Would you like to be on our E-Mail list? Yes_____ No Thank You _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Engaged

If Married, Spouse's Name: _____ Spouse's Employer: _____

Family Physician and/or Other Health Care Provider: _____

Emergency Notification / Next of Kin

Name: _____ Relationship to Client: _____

Address: _____
PO Box or Street City State Zip

Phone#: Home_____ Work_____ Cell_____

BACKGROUND INFORMATION

Name_____ Date_____
Please complete the following information. Thank you.

HEALTH INFORMATION
Have you had recent surgeries? If yes, what?_____
What medications are you currently taking and what are the dosages?

_____
Are you currently using cigarettes?_____Amount?_____
If you use alcohol, how much and what kind?_____
If you use street drugs, how much and what kind?_____

_____
Have you been hospitalized for substance use or for psychiatric care? If so, when and where?_____
Do you eat regularly?_____Do you pay attention to your nutrition? Yes_____No_____
How many caffeinated beverages (coffee, colas, teas) do you drink in a day? Give type of drink and amount_____
How much do you exercise per week?_____

FAMILY BACKGROUND INFORMATION
Were you raised in a two-parent family? Yes____ No____
Are you an only child? Yes_____ No_____If no, what is your birth order relative to your siblings?_____
Was divorce part of your family history? Yes_____ No_____
How would you describe your family environment?
Warm and affectionate____, Non-demonstrative of affection_____, cold_____, impersonal_____, confusing and unpredictable_____, physically abusive_____, sexually abusive_____, violent and dangerous_____,
other_____

Marital status: single_____married_____significant other_____separated_____divorced_____, with a friend_____, other_____
Children? Names and ages_____
_____

Describe your current relationships in general_____
_____
Religion: Raised in any denomination_____
Current level of church monthly_____
_____
_____

EDUCATIONAL BACKGROUND INFORMATION:

What is your level of education? Grade,____High, ____GED, ____2-year tech____
4-yr college, _____Add'l yrs. of college____Degrees_____
Are you currently enrolled in classes or training?
No____Yes/place_____
Currently employed? No_____Yes_____Occupation_____
Where and how long?_____
What other kinds of work have you done?_____

COUNSELING BACKGROUND
Have you had previous counseling? Yes____ No____ If yes, when and what kind of counseling have you recreceived?_____
_____
_____

CURRENT ISSUES _____Please check the issues that concern you at this time:

_____relationship with spouse/partner
_____relationship with parents/family
_____relationship with girl/boy friend
_____relationship with foster family
_____parenting your children
_____divorce/custody
_____legal matters
_____financial problems
_____unemployment
_____physical health
_____grief
_____meaninglessness
_____depression
_____thoughts of suicide
_____eating disorders
_____hopelessness
_____intrusive voices
_____partner of a dissociative
_____child abuse or neglect
_____physical abuse
_____not feeling very alive
_____fears
_____unwanted habits
_____sexual desire
_____sexual performance
_____sexual assault
_____date rape
_____incest/molest
_____alcohol use or abuse
_____drug use or abuse
_____parents abuse of substances
_____fear of dying or death
_____aloneness
_____low self-esteem
_____thoughts of harming others
_____sleep problems
_____mental illness
_____dissociation
_____anger
_____lifestyle discrimination
_____sexual abuse
_____no direction in my life

Other_____
Thank you!

MY ISSUES, GOALS, AND USE OF THERAPY – PART I

What are the major issues that bring you to counseling now?

_____
_____
_____
_____

What do you want from therapy (my goals)? I want_____
_____
_____
_____
_____
_____
_____

How will you know when you have achieved your goals (feelings, behaviors)? I will know that I am achieving or have achieved my goals by:

_____
_____
_____
_____
_____
_____

Number of sessions available_____or anticipated length of treatment_____

To achieve my above goals:

I agree to participate in counseling/therapy with Jane St. Pierre, LCSW, for as long as I shall consider the therapy beneficial to me in the achievement of my goals. If I disagree with the process of the results, I will discuss this with her. I understand that the number of my sessions may be limited if I have insurance.

As a client in counseling/therapy, I will work on my issues, try to complete any agreement on assignments, and be as honest as I am able to myself and to the therapist. I expect the therapist to use all her skills to guide and assist me in the achievement of my goals.

Any matters discussed in individual sessions is considered confidential. Any matters discussed in group is held in strict confidentiality by all the members of the group.

I am aware that the therapist is bound by law to report current child abuse or endangerment of life to appropriate authorities.

Signed_____Date_____

ISSUES, GOALS, AND USE OF THERAPY – PART II
(To be completed after discussion with the therapist.)

For the accomplishment of the above, I agree that the fee for individual sessions is

$_____for _____minutes
for_____group sessions is $_____

Signed_____Date_____

Therapist_____Date_____

Jane St.Pierre, ***LCSW***
1955 W. Grant Road #125
Tucson, AZ 85745
520-429-3673

CONSENT FOR TREATMENT

This consent for treatment details some guidelines for our work together. I view therapy as a collaboration between client and therapist aimed at understanding one's self, as well as current and past life experiences. I also consider therapy as a collaboration in developing strategies, skills and actions which intend to reduce emotional distress, increase self satisfaction and clarify life goals, setting your future on a solidly better path. Some possible benefits of therapy include**: e**nhanced understanding of yourself & others; improvement in your relationships; reduction in presenting symptoms; greater ability to cope with stress, and work through difficulties; improvement in job or school performance; strengthened overall sense of well-being.

Psychotherapy is not an exact science. Each individual is unique. Most people, but not all, experience many of the benefits described above but it does take time. Please be aware however, in some ways many people may feel worse, before they feel better. For instance you may experience an in session temporary increase in symptoms or emotions, such as sadness, grief or anger as your buried issues are more directly faced in order to clear the buried toxicity out. And it is possible, through making these changes, tho you internally feel better and stronger, you may actually experience a temporary increase in conflicts with significant others, who are uncomfortable with your improvements.

You are assured complete confidentiality except for when you specifically authorize me to release information regarding your therapy for coordination of care or insurance reimbursement. There are times when I have a duty to report, to appropriate authorities, it is required by law IF, an individual poses a danger to self, danger to others or in cases of child abuse, elder abuse or when mandated by a court order. In order to provide you with the best possible treatment experience, there may be a time I participate in consultation and trainings with other professionals. Unless I obtain written authorization from you, identification is not by name, but by vague circumstance. Please respect the confidentiality of others seen or met in the counseling office or sessions.

I offer individual, couples and family therapy. Please be advised I am not a child custody or divorce expert, therefore I do not offer these expert witness services.

Individual sessions are typically 45 minutes long, however different time stipulations can be required according to insurance coverage and benefits. Unless cancelled at least 24 hours in advance, you will be responsible to pay a $60 fee to partially compensate for the missed revenue (not just the insurance co pay). Tho only the full 24 hours notice is necessary I'm requesting, as a thoughtful courtesy to me and to others waiting for appointments, please call as soon as you know you'll need to reschedule. I have a confidential voice mail available to accept messages 24 hours a day.

I am a Participating Provider with the following insurance companies; Blue Cross Blue Shield of AZ, Optum (previously United Behavioral health Care and Untied Health Care), Aetna and Cigna. By signing below you authorize me to communicate with and bill your insurance carrier directly for your

remaining payment and authorizing them to pay the remainder of the bill directly to me, the provider. You are responsible for all co-pay amounts and deductibles at time of service. If your portion of payment is not paid at time of service a $20 late fee will be applied and the client will be fully responsible for any additional fees charged by banks for returned checks.

As part of your self-care and healthy functioning, I support and encourage you to develop and utilize a support system outside of therapy that you can rely on when the need arises between sessions. The nature of my practice is that of outpatient services, by appointment. This assumes that all clients are self-responsible, e.g. functioning and not in need of day-to-day supervision. I cannot assume responsibility for your day-to-day functioning, ONLY a hospital or inpatient facility can. My services are not sufficient for emergency, nor life threatening situations. In the event that is the case, at any time, or if you are in need of an immediate intervention, by signing below you are agreeing, at times like this to responsibly dial 911 or call the Crisis Response Center at 622-6000 to get immediate intervention from these larger organizations. The Crisis Center is open 24 hours a day, 365 day a year. You may also go to the nearest hospital emergency room for an immediate evaluation and intervention at any time.

I have read this entire Consent for Treatment, consisting of two pages, and I understand and agree to these arrangements and to participate actively in a dedicated manner in the therapy process. I also agree to meet all financial obligations that I incur in my treatment and to take care of all professional fees as described above. With this understanding agreed upon as signed below I request the professional services of Jane St Pierre, LCSW.

Termination is actually a really important part of the therapeutic treatment process, regardless of how many sessions you have had. You have a right to the benefit of closing in the most therapeutically beneficial manner, by advising me directly of your intent and reasons to leave therapy instead of just not returning; revoking consent to treatment can be done at any time, verbally or in writing.

I have also received a copy of my HIPAA rights and accompanying promise of privacy, with the understanding of exceptance being, information ONLY to be released to said insurance responsible for payment, upon request.

I look forward to working with you on the fulfillment of your desired goals.

Client (print name)_____

Client signature _____

Date_____

Therapist_____ Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Practice is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact Jane St. Pierre at 520-429-3673, herein referred to as 'the Practice.'

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to our Practice, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate heath professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan you meals. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside the Practice who may be involved in your medical care after you leave our care. This may include family members, or visiting nurses to provide care in your home.
- **For Payment**. We may use and disclose health information about you so that the treatment and services you receive may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Health-Related Benefits and Services and Reminders**. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Law Enforcement**. We may disclose health information when requested by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
  - About a death we believe may be the result of criminal conduct;
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of the Practice, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your health information.

  You must submit your request in writing to the Practice. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to Request Alternate Communications**. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

  You must submit your request in writing to the Practice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

  To obtain a paper copy of this Notice, contact the Practice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Practice administrator.