High Country Child & Family Wellness Center
Consent to Treatment and Recipient's Rights

Client___________________________________ Chart #___________________________________

I, ____ the undersigned, hereby attest that I have Voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at High Country Child & Family Wellness Center hereby referred to as the Center. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Nonvoluntarily Discharge from Treatment: A client may be terminated from the Center nonvoluntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the nonvoluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Center is protected by federal and/or state law and regulations. Generally, the Center may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of nonemancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with ___________________________________.

____ _____________________

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

____ _____________________

Witness Date

CONTENT TO USE OR DISCLOSE INFORMATION FOR TREAMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Dr. Julia Summers PhD, LPC

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (Know as "health care operations"). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practice before signing this consent. I reserve the right to revise the notice of Privacy Practices at any time. If I do so, the revised notice will be posted in the office. You may ask for a printed copy of the notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or healthcare operations; however, I do not have to agree to theses restrictions. If I do agree to the restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

____

Client/parent/guardian (Print) Date Signature

____

Client/parent/guardian (Print) Date Signature

High Country Child & Family Wellness Center
Dr. Julia Summers PhD, LPC   Financial Policy

The staff at High Country Child & Family Wellness Center (hereafter referred to as the clinic) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the clinic will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections. A 1% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the clinic by the insurance company or third-party provider.

All insurance benefits will be assigned to this clinic (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Payment methods include check, cash, or the following charge cards: _____________________ Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by Dr. Julia Summers.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account; ______________________________   Date:______/_______/_______

Co-responsible party: ______________________________________   Date:______/_______/_______

High Country Wellness Center, LLC
Dr. Julia Summers PhD, LPC
335 Park Avenue
Prescott, AZ 86303
Phone (928) 499-0760

AGREEMENT/INFORMED CONSENT/PRIVACY ACT FOR PSYCHOTHERAPY SERVICES OFFICE POLICES & GENERAL INFORMATION

This form provides you (client) with information that is additional to that detailed in the HIPAA Notice of Privacy Practices.

INFORMED CONSENT TO TREATMENT: client and/or guardian consent to treatment by Dr.Julia Summers, PhD, LPC including any testing, diagnosis, and treatment provided.

LENGTH OF TREATMENT: treatment typically involves regular sessions, usually 50 minutes in length. Duration of treatment varies depending on the nature of the problem(s) and your individual needs.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining where the law requires disclosure were described to you in the HIPAA Notice of Privacy Practices that you received with this form.

When Disclosure Is Required by Law: Some of the circumstances where disclosure is required by law are: where there is a reasonable suspicion of child, dependent, or elder, abuse, exploitation or neglect; and where a client presents a danger to self, to others, to property, persistently or acutely disabled, or is gravely disabled, or when client's family member/s communicate to Dr.Julia Summers, LPC that the client presents a danger to others (For more details also see Notice Of Privacy Practices Form).

When Disclosure May Be required: Disclosures may be required pursuant to the legal proceedings. If you place your mental health status at issue in litigation by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Dr.Julia Summers, LPC. In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couples or among the family members. Dr.Julia Summers, LPC will use her clinical judgment when revealing such information. Dr. Julia Summers, LPC will not release records to any outside party unless she is authorized to do so by **all** adult family members who were part of the treatment.

EMERGENCIES: If there is an emergency during our work together, or in the future after termination, where Dr.Julia Summers, LPC becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct Dr.Julia Summers, LPC, only the minimum necessary information will be communicated to the carrier. Dr.Julia Summers, LPC has no control or knowledge over that the insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to the future eligibility to obtain health or life insurance. The risk stems from the fact that mental health insurance is entered into insurance companies' computers and soon will also be reported to the congress-approved, National Medical Data Bank. Accessibility to companies' computers or the National Medical data bank is always in question, as the computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Confidentiality of E-mail, Cell phone, and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be easily sent erroneously to the wrong address. There is no guarantee of confidentiality through e-mail or fax

correspondence. Please notify Dr.Julia Summers, LPC at the beginning of treatment if you decide to avoid or limit in any way the use of any or all the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies.

Litigation Limitations: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regards to many matters which may be of a confidential nature, it is agreed that it should there be a legal proceeding (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc) neither you (client) nor your attorney, nor anyone else acting on your behalf will call Dr.Julia Summers to testify unless agreed upon with Dr.Julia Summers, LPC.

Counselor/Psychotherapist Incapacitation or Termination of Practice: If Dr.Julia Summers, LPC should become incapacitated through death, disability, or change in her practice, Susan Armstrong, LPC will be the custodian of her records. She may be reached at (928) 277-0452, for access to the records as well as information about continuity of services with another health practitioner.

Consultation: Dr. Julia Summers, LPC may consult with other professionals regarding her clients in order to provide high quality treatment. However, the client's name or other identifying information will never be mentioned. The client's identity will remain completely anonymous and confidentiality is fully maintained. When away from the office for a few days, she has a trusted fellow clinician "cover". This clinician is available to you in emergencies. Therefore, he or she needs to know about you. Dr.Julia Summers, LPC will only tell this clinician what he or she needs to know for an emergency. Of course, this clinician is bound by the same laws and rules to protect your confidentiality.

- Considering all the above exclusions, if it is still appropriate, upon your request, Dr.Julia Summers, LPC will release information to any agency/person you specify unless Dr.Julia Summers, LPC concludes that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Dr. Julia Summers, LPC between sessions, please leave a message and your call will be returned as soon as possible. Dr. Julia Summers, LPC checks her messages a few times a day, unless she is out of town. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the West Yavapai Guidance Clinic Crisis Line at (928) 445-5211 or the Police (911). The West Yavapai Guidance Clinic has walk-in crisis services at 642 Dameron Drive in Prescott. You can also go to the emergency room at the hospital for help.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the agreed upon fee at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify Dr. Julia Summers, LPC if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, Dr. Julia Summers, LPC will, upon request, provide you with a copy of your receipt on monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the sections, ***Health Insurance & Confidentiality of Records***, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues /conditions /problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of you coverage.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Dr. Julia Summers, LPC and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Yavapai County, Arizona, in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Dr. Julia Summers, LPC can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honest, and openness in order to change your thoughts, feelings and/or behavior. Dr. Julia Summers, LPC will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will

expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Dr. Julia Summers, LPC may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes, another family member can view a positive decision for one family member quite negatively. Change will sometimes be easy and swift, but more often it will be slow and even frustration. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Dr. Julia Summers, LPC is likely to draw on various psychological and counseling approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. Theses approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

DISCUSSION OF TREATMENT PLAN: Within a reasonable period of time after the initiation of treatment, Dr. Julia Summers, LPC will discuss with you (client) her working understanding of the problem, treatment plan, therapeutic objectives, and her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Dr. Julia Summers' expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Dr. Julia Summers, LPC does not provide, she has an ethical obligation to assist you in obtaining those treatments.

TERMINATION: As set forth above, after the first couple of meetings, Dr. Julia Summers, LPC will assess if she can be of benefit to you. Dr. Julia Summers, LPC does not accept clients who, in her opinion, she cannot help. In such a case, she will give you a number of referrals that you can contact. If at any point during psychotherapy, Dr. Julia Summers, LPC assesses that she is not effective in helping you reach the therapeutic goals, she is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, Dr. Julia Summers, LPC will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, Dr. Julia Summers, LPC will assist you in finding someone qualified, and, if she has your written consent, she will provide her or him with essential information needed. You have the right to terminate therapy at any time. If you choose to do so, Dr. Julia Summers, LPC will offer to provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Dr. Julia Summers', LPC objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. Dr. Julia Summers, LPC will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Prescott is a small community and many clients know each other and Dr. Julia Summers, LPC from the community. Consequently, you may bump into someone you know in the waiting room or into Dr. Julia Summers, LPC out in the community. Dr. Julia Summers, LPC will discuss with you, her client(s), the often-existing complexities, potential benefits, and difficulties that may be involved in such relationships. It is your, the client's, responsibility to communicate to Dr. Julia Summers, LPC if any existing dual relationship becomes uncomfortable for you in any way. Dr. Julia Summers, LPC will always listen carefully and respond accordingly to your feedback. Dr. Julia Summers, LPC will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapeutic process or the welfare of the client and, of course, you and do the same at any time. Because Dr. Julia Summers, LPC does outpatient counseling/therapy, she cannot promise to be available at all times. Although in the office Monday through Thursday, 8:00 a.m. to 6 p.m. she usually does not take phone calls when with a client. You can always leave a voice mail message and your call will be returned as soon as possible.

BILLING SERVICES:
Paragon Billing
Phone # 952-835-3938

Qualifications and Experience: Dr. Julia Summers, LPC

I am licensed by the states of Arizona and Oregon as Licensed Professional Counselor (LPC), which allows me to have an independent practice. I work with a variety of presenting difficulties that affect individuals, families, groups, and relationships. I have specialization in stress management and work place wellness.

I hold a Master's Degree in Counseling, and a PhD in Psychology and Specialization in Family Psychology. I am nationally certified by the National Board for Certified Counselors (NBCC). I am a current member of the American Psychological Association. (APA).

Thank you for allowing me to be part of your total health and wellness.

Client/Parent/Guardian (print) Date Signature

High Country Child & Family Wellness Center
Dr.Julia Summers PhD, LPC
335 Park Avenue
Prescott, AZ 86303
Phone (928) 499-0760

AUTHORIZATION TO RELEASE INFORMATION

I, ____________________________, (hereinafter "Client") DOB: __________.
Hereby authorize **Dr.Julia Summers, PhD, LPC** (hereinafter "Provider") to disclose and receive treatment information and records related to the psychotherapy treatment of client, including, but not limited to, therapist's diagnostic impression of client, to and from:

NAME: ____

ADDRESS: ____
Street

____
City State Zip

____
Phone Fax

Purpose: This disclosure of information and records authorized by Client is required for the purpose of improving assessment and treatment planning, sharing information relevant to treatment and when appropriate, coordinate treatment services.

Description Of Information to be Disclosed: Such disclosure shall be limited to the following specific types of information (circle all that apply All types following assessment, diagnosis, psychosocial evaluation, psychological evaluation, psychiatric evaluation, history & physical, consultation, treatment plan or summary, current treatment update, presence/participation in treatment, discharge summary, progress notes, demographic information, court/legal records, drug/alcohol abuse records: Other ______

Revocation: I understand that I have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by the provider at one of the addresses at the top of this form to be effective.

Conditions: Provider shall not condition treatment upon Client signing this authorization and the Client has a right to refuse to sign this form.

Redisclosure: Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule, although applicable Arizona law may protect such information. Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person whom it pertains as or otherwise permitted by 42 C.F.R,. Part 2.

This authorization shall remain valid until________________________________

____
Client/parent/guardian (print) Date Signature

____
Client/parent/guardian (print) Date Signature

____
Witness (print) Date Signature

Insurance Verification Form and Patient Information

Patient/Subscriber Information Date: ____________

Patient Name: ____

Date of Birth ____

Home Address: ____

Phone Number: ____

Patient Social Security Number: ____

Subscriber Name: ____

Relationship to Patient: _______________ Subscriber date of birth: ___________

Benefit Verification:

Insurance Company Name:

____

Insurance I.D # (include letters): ____

Insurance Phone # Called: ____

Effective Date of coverage: ____

Deductible?____

Any deductible met? ______________ Co-pay? _____ Visit maximum? ________

Authorization required? Y N If yes, Authorization
Number:____

Start and End Date of Authorization: ____

Mail Claims to:

____

High Country Wellness Center Mental Health Screening Form

Name: ____________________________________ Date: __________________

1. Do you have any history of treatment from mental health professionals due to emotional or behavior problems? ____No ____Yes

If yes, please answer a & b.

   a. Are you currently seeing a mental health professional? ____No ____Yes
   b. How many years total have you received mental health services? ____________

2. Have you ever been hospitalized for mental health reasons?
   ____No ____Yes Date(s): ____
   For what purpose(s): _________________________________

3. Do you have any history of taking medications for mental health? ____No ____Yes

4. Check any of the following symptoms that are concerns for you.

____Anxiety
____Aggression
____Concentration
____Crying spells
____Depression
____Fatigue
____Fears
____Hallucinations
____High energy
____Hopelessness
____Hyperactivity
____Impulsive behaviors
____Irritability
____Intrusive thoughts
____Lack of pleasure
____Low motivation
____Nightmares
____Obsessive thoughts
____Panic attacks
____Restlessness
____Substance abuse
____Sleeping problems
____Suicidal thoughts
____Trembling
____Other____
____Other____

5. Check any areas in which mental health concerns are affecting your functioning.

____Emotionally
____Marriage/family
____Physically
____School
____Sexually
____Socially
____Work
____Other____________________________________

6. Are you taking any medications? Please list below

____

____

Payment Contract for Services

Name(s): ____
Address: ____________________ City: _______________ State: ________ Zip: ____________
Bill to: Person responsible for payment of account: ____
Address: ____________________ City: _______________ State: ________ Zip: ____________

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

PART ONE FEES FOR PROFESSIONAL SERVICES

I (we) agree to pay ________________, hereafter referred to as the clinic, a rate of $ ______________ per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family and relationship counseling).
A fee of $ ______________ is charged for group counseling. The fee for testing includes scoring and report-writing time.
A fee of $ ______________ is charged for missed appointments or cancellations with less that 24 hours' notice.
A fee of $ ______________ per hour is charged for services not covered by insurance, such as court appearances, extra report writing time, and any other services not covered by insurance.

PART TWO CLIENTS WITH INSURANCE (DEDUCTIBLE AND CO-PAYMENT AGREEMENT)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

ESTIMATED INSURANCE BENEFITS

1) $ _____________ Deductible amount (paid by insured party)
2) Co-payment _______ % ($ ______/clinical unit) for first __________________ visits.
3) Co-payment _______ % ($ ______ /clinical unit) up to ___________________ visits.
4) The policy limit is ________ per year: ______ annual _____________________ calendar

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy, all co--payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

PART THREE ALL CLIENTS

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _________________________

Date: ______/______/______

RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I (we) authorize __________________ to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above-listed third-party payer or insurance company for the purpose of receiving payment directly to ________________________________.

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: ______________________________ Date: _____/_____/______

Person(s) receiving services: ___________________________________ Date: _____/_____/______

Person(s) or guardian(s): ______________________________________ Date: _____/_____/______

High Country Child & Family Wellness Center Personal History

Client's name: ____ Date: __________________

Gender: ____ F ____ M Date of birth: _______________________ Age: __________________

Form completed by (if someone other than client): ____

Address: _______________________ City: _______________ State: ______ Zip: ________

Phone (home): ____________________ (work): _________________________ ext: _________

If you need any more space for any of the questions, please use the back of the sheet.

Primary reason(s) for seeking services

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concers

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs

___ Other mental health concerns (specify): ____

FAMILY INFORMATION

Relationship	Name	Age	Living: Yes	Living: No	Living with you: Yes	Living with you: No
Mother	_________________________	_________	____	____	____	____
Father	_________________________	_________	____	____	____	____
Spouse	_________________________	_________	____	____	____	____
Children	_________________________	_________	____	____	____	____
	_________________________	_________	____	____	____	____
	_________________________	_________	____	____	____	____

Significant others (e.g., brother, sisters, grandparents, steprelatives, half relatives. Please specify relationship.)

Relationship	Name	Age	Living: Yes	Living: No	Living with you: Yes	Living with you: No
__________	_________________________	_________	____	____	____	____
__________	_________________________	_________	____	____	____	____
__________	_________________________	_________	____	____	____	____
__________	_________________________	_________	____	____	____	____
__________	_________________________	_________	____	____	____	____
__________	_________________________	_________	____	____	____	____

Marital Status (more than one answer may apply)

____ Single

____ Divorce in process
Length of time: ___________

____ Unmarried, living together
Length of time: ____________

____ Legally married
Length of time: ___________

____ Separated
Length of time: ___________

____ Divorced
Length of time: ____________

____ Widowed
Length of time: ___________

____ Annulment
Length of time: ___________

Total number of marriages: ___

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

PARENTAL INFORMATION

____ Parents legally married

____ Mother remarried: Number of times: ________

____ Parents have ever been separated

____ Father remarried: Number of times: ________

____ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): ____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? __Yes ___ No

If Yes, please describe: ____

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): ______

Comments re: childhood development: ____

____

SOCAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

____ Other (specify): ____

Sexual orientation: _________________ Comments: ____

Sexual dysfunctions? ____ Yes ____ No

If Yes, describe: ____

CULTURAL ETHIC

To which cultural or ethnic group, if any, do you belong? ____

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No

If Yes, describe: ____

Other cultural/ethnic information: ____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much

Are you affiliated with a spiritual or religious group? ____ Yes ____ No

If Yes, describe: ____

Were you raised within a spiritual or religious group? ____ Yes ____ No

If Yes, describe: ____

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes ____ No

If Yes, describe: ____

LEGAL

CURRENT STATUS

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: ____________________

____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: ____

PAST HISTORY

Traffic violations:	____ Yes	____ No	DWI, DUI, etc.:	____ Yes	____ No
Criminal involvement:	____ Yes	____ No	Civil involvement:	____ Yes	____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

____

EDUCATION

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes____ No

____ High school grad/GED

____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____________
____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____________
____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____________

Other training: ____

Special circumstances (e.g., learning disabilities, gifted): ________________________________

EMPLOYMENT

Begin with most recent job, list job history: ____

Employer	Dates	Title	Reason left the job	How often miss work?
______________	____________	____________	______________	___________________
______________	____________	____________	______________	___________________
______________	____________	____________	______________	___________________

____

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired

____ Social Security ____ Student ____ Other (describe): ________________________________

MILITARY

Military experience? ____ Yes ____ No Combat experience? ____ Yes ____ No

Where: ____

Branch: ________________________ Discharge date: __________________________

Date drafted: _____________________ Type of discharge: ________________________

Date enlisted: _____________________ Rank at discharge: ________________________

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____________________	_____________________	_______________________
_____________________	_____________________	_______________________
_____________________	_____________________	_______________________
_____________________	_____________________	_______________________

MEDICAL/PHYSICAL HEALTH

____ AIDS ____ Dizziness ____ Nose bleeds

____ Alcoholism	____ Drug abuse	____ Pneumonia
____ Abdominal pain	____ Epilepsy	____ Rheumatic fever
____ Abortion	____ Ear infections	____ Sexually transmitted diseases
____ Allergies	____ Eating problems	____ Sleeping disorders
____ Anemia	____ Fainting	____ Sore throat
____ Appendicitis	____ Fatigue	____ Scarlet fever
____ Arthritis	____ Frequent urination	____ Sinusitis
____ Asthma	____ Headaches	____ Smallpox
____ Bronchitis	____ Hearing problems	____ Stroke
____ Bed-wetting	____ Hepatitis	____ Sexual problems
____ Cancer	____ High blood pressure	____ Tonsillitis
____ Chest pain	____ Kidney problems	____ Tuberculosis
____ Chronic pain	____ Measles	____ Toothache
____ Colds/Coughs	____ Mononucleosis	____ Thyroid problems
____ Constipation	____ Mumps	____ Vision problems
____ Chicken pox	____ Menstrual pain	____ Vomiting
____ Dental problems	____ Miscarriages	____ Whooping cough
____ Diabetes	____ Neurological disorders	____ Other (describe): __________
____ Diarrhea	____ Nausea	______________________________

List any current health concerns: ____

List any recent health or physical changes: ____

____

NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	____ /week	_________________	____ No	____ Low	____ Med	____ High
Lunch	____ /week	_________________	____ No	____ Low	____ Med	____ High
Dinner	____ /week	_________________	____ No	____ Low	____ Med	____ High
Snacks	____ /week	_________________	____ No	____ Low	____ Med	____ High

Comments: ____

Current prescribed medications	Dose	Dates	Purpose	Side effects
____________________	________	__________	____________	____________________
____________________	________	__________	____________	____________________
____________________	________	__________	____________	____________________
____________________	________	__________	____________	____________________

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
____________________	________	__________	____________	____________________
____________________	________	__________	____________	____________________
____________________	________	__________	____________	____________________
____________________	________	__________	____________	____________________

Are you allergic to any medications or drugs? ____ Yes ____ No

If Yes, describe: ____

____

	Date	Reason	Results
Last physical exam	________	____________________	________________________

Last doctor's visit	________	____________________	________________________
Last dental exam	________	____________________	________________________
Most recent surgery	________	____________________	________________________
Other surgery	________	____________________	________________________
Upcoming surgery	________	____________________	________________________

Family history of medical problems: ____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: ________________________________

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	____________	_______	______	______	___	___	___	___
Barbiturates	____________	_______	______	______	___	___	___	___
Valium/Librium	____________	_______	______	______	___	___	___	___
Cocaine/Crack	____________	_______	______	______	___	___	___	___
Heroin /Opiates	____________	_______	______	______	___	___	___	___
Marijuana	____________	_______	______	______	___	___	___	___
PCP/LSD/Mescaline	____________	_______	______	______	___	___	___	___
Inhalants	____________	_______	______	______	___	___	___	___
Caffeine	____________	_______	______	______	___	___	___	___
Nicotine	____________	_______	______	______	___	___	___	___
Over the counter	____________	_______	______	______	___	___	___	___
Prescription drugs	____________	_______	______	______	___	___	___	___
Other drugs	____________	_______	______	______	___	___	___	___

Substance of preference

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

SUBSTANCE ABUSE QUESTIONS

Describe when and where you typically use substances: ____

____

Describe any changes in your use patterns: ____

____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): __________________________

How do you believe your substance use affects your life? ____

Who or what has helped you in stopping or limiting your use? ____________________________________

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: ____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: ____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _________________________

____

Does your body temperature change when you drink? ____ Yes ____ No

If Yes, describe: ____

Have drugs or alcohol created a problem for your job? ____ Yes ____ No

If Yes, describe: ____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	___________	_______________	______________
Suicidal thoughts/attempts	____	____	___________	_______________	______________
Drug/alcohol treatment	____	____	___________	_______________	______________
Hospitalizations	____	____	___________	_______________	______________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	___________	_______________	______________

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	___________	________________	________________
Suicidal thoughts/attempts	____	____	___________	________________	________________
Drug/alcohol treatment	____	____	___________	________________	________________
Hospitalizations	____	____	___________	________________	________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	___________	________________	________________

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression
____ Alcohol dependence
____ Anger
____ Antisocial behavior
____ Anxiety
____ Avoiding people
____ Chest pain
____ Cyber addiction
____ Depression
____ Disorientation
____ Distractibility
____ Dizziness
____ Drug dependence
____ Eating disorder
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Other (specify): ________
____

Briefly discuss how the above symptoms impair your ability to function effectively: ________________

____

____

____

____

____

____

____

____

Any additional information that would assist us in understanding your concerns or problems: ________

____

____

____

____

____

____

____

What are your goals for therapy? ____

____

____

____

____

____

____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, explain: ____

____

____

____

FOR STAFF USE

Therapist's signature/credentials: ______________________________ Date: ____/____/______

High Country Wellness Center, LLC
Dr. Julia Summers, Ph.D., LPC

Please Print Clearly
Date________________ Client's Social Security # __________________
Client's First Name ___________________ Last Name _________________
MI ______________
Address ________________ City ______________ State____________
Zip _______________
Telephone (Home) ____________________________ (Work) ______________________________
Birth date _____/_____/_____ Age ______ Gender _____F _____M __
Name of Spouse/Guardian ___________________________ Phone _________________________
Address ______________________ City _______________ State _____________ Zip ________
Person Responsible for Payment _________________________ Soc. Sec. # ____________________
Signature of Person Responsible for Payment X _____________ (Must be signed for services to begin)

EMERGENCY INFORMATION

In case of emergency, contact:
Name (1) __________________ Relationship __________ Phone __________ Work ________
Address ___________________ City _________________ State _________
Zip ____________
Name (2) __________________ Relationship __________ Phone __________ Work ________
Address ___________________ City _________________ State _________
Zip ____________
Psychiatrist ____ Phone ________________
Address ___________________ City _________________ State _________
Zip ____________
Current Medications
____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place ______________________________ Phone ____________ Hrs ___________

Spouse: Place _____________________________________ Phone ____________ Hrs ___________

INSURANCE INFORMATION

Primary Insurance ________________________ Secondary Insurance _______________________

Phone__________________________________ Phone___________________________ ________

Contract/ID# ____________________________ Contract/ID# _____________________________

Group/Acct#_____________________________ Group/Acct# _____________________________

Subscriber_______________________________ Subscriber _______________________________

Subscriber Date of Birth____________________ Subscriber Date of Birth_____________________

Client's relationship to Subscriber Client's relationship to Subscriber

___Self ___Spouse ___Child ___Other_________ ___Self ___Spouse ___Child ____Other________

PROVISIONS: Client pays $_____________ Deductible amount Amount satisfied: $_______________

Insurance pays__________ % for visits____–____ and__________ % for visits____–____

Type(s) of providers covered: ___________________________ Supervision: ____________________

REFERRAL SOURCE

How did you hear of our office (or from whom)? ____

High Country Child & Family Wellness Center Substance Abuse Screening Form

Name:____ Date: ___________________

1. Do you have any history of treatment for substance abuse? ____Yes ____No

If yes, please answer the following question.

Are you currently receiving treatment for substance abuse? ____Yes ____No

2. Check any of the following which best describes your use of drugs or alcohol.
   - ____I have never had any problems with substance abuse.
   - ____I have no problems at this time.
   - ____I have only a few concerns at this time.
   - ____I am in recovery. (Last use ___________________________________)
   - ____I am an addict.

3. Do you have any family history of substance abuse? ____Yes ____No

4. When is the last time you used illegal drugs?

   ___Today ___Past week ___Past month ___Past 6 months ___Over 1 year ___Never

5. When is the last time you used alcohol?

   ___Today ___Past week ___Past month ___Past 6 months ___Over 1 year ___Never

6. When is the last time you misused prescription drugs?

   ___Today ___Past week ___Past month ___Past 6 months ___Over 1 year ___Never

7. Has anyone ever told you that you have a problem with substance abuse? ____Yes ____No

8. Have you ever tried to stop using substances but couldn't? ____Yes ____No

9. Has the use of substances ever affected you in any of the following areas?

___Finances ___Friendships ___Health

___Marriage/Family ___School ___Work

____Other____________________________ ____Other___________________________________