Adult Counseling Intake

Name: _____ Today's Date_____
Date of Birth _____Age _____

Reason for Today's Visit: _____
_____
_____

Referred By: _____

Occupation/ Workplace: _____
Cell Phone: ( )_____
Email Address: _____
Preferred form of contact: (circle) CP EMAIL HM WK

Home Address: _____
_____
City_____State_____Zip _____
Major Cross Streets:_____

Emergency Contact: _____ ( ) _____

Medical Information

Primary Care Doctor: _____ Phone ( ) _____
Psychiatric Care Provider: _____ Phone ( ) _____
Last Seen: _____
Psychiatric Diagnosis (if known): _____
Current Medications: (include prescriptions, vitamins, supplements, OTC, etc.)

Medication:	Dosage:	Prescribed For:	How long taken?

ER/UrgentCare/Hospitalizations over past year: YES NO
Reason:_____

Significant Medical History: (circle one) YES NO N/A
If YES, explain:
_____
_____
_____
_____

Significant Psychiatric History/Current Treatment: (circle one) YES NO N/A
If YES, explain: (Include dates of treatment, places, etc)

_____
_____
_____
_____

Significant Chemical Dependency History/Current Treatment: (circle one) YES NO N/A
If YES, Explain: (Include dates of treatment, places, etc)

_____
_____
_____
_____
_____
_____

Psychosocial Information

Recent Environmental Changes: (Over past year)

○ Change in Physical/Mental Health	○ Occupational Change	○ Divorce
○ Change in Family Dynamic	○ Blended Family Issues	○ Loss of a Loved One

Symptoms Checklist: Check the following CURRENT complaints: (check all that apply**)**

- ○ Learning Disabilities
- ○ Occupational Problems
- ○ Marital Problems
- ○ Health Problems
- ○ Legal Problems
- ○ Suicidal Thoughts
- ○ Inappropriate Interactions with Peers
- ○ Sleep Disturbance

Symptoms Checklist: Check the following complaints over the PAST YEAR: (check all that apply**)**

- ○ Learning Disabilities
- ○ Occupational Problems
- ○ Marital Problems
- ○ Health Problems
- ○ Legal Problems
- ○ Suicidal Thoughts
- ○ Inappropriate Interactions with Peers
- ○ Sleep Disturbance

Marital Status: I am currently: (circle) single married separated divorced widowed
I have been married _____ and divorced _____times.
I am here today for couples' counseling. YES or NO.
*****If Yes, please fill out Couples Supplemental Forms** (see website).

Family Information:

Child	Age	Lives HM or away?	Health/Med Issues

Missed/Cancelled Appointment Policy

Appointments MUST be cancelled 24-hour notice prior to cancellation.

MISSED APPOINTMENTS: When an individual misses an appointment, and has not called to cancel that appointment at least 24 hours before a scheduled time, this is considered a missed appointment. The client will be responsible for the full fee of the counseling session for missed appointments. This payment will be due before that next appointment can be scheduled.

I have read and received a copy of this policy. I understand and agree with the policy that I will be responsible for the full counseling fee before my next appointment will be scheduled.

Signature: _____Date: _____

Service Agreement

My therapist has discussed services and fees with me, and I have agreed to pay for these services. I understand that all services are provided on a prorated basis at the rate of (See Chart) per fifty-five minute hour. I understand that additional travel fees may be added depending on location.

I understand that if I fail to cancel my appointment within 24 hours of a scheduled session I will be charged the full fee amount.

My signature below indicates that I understand and agree to the above conditions. I consent to participate in services from The Bravo Effect.

Signature: _____Date: _____

Informed Consent for Treatment, Evaluation, and Consultation

Welcome to my counseling practice. I am committed to getting you whatever your outcome is for our time together. A counseling situation offers a unique relationship between the two of us. In order that we start our relationship in a healthy way, I have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling and psychotherapy services.

Background and Services. I have a **Doctorate of Behavioral Health** and am a **Licensed Professional Counselor** and a **Licensed Independent Substance Abuse Counselor** in an independent counseling and consultation practice. I may share my office suite with other licensed professionals, but we are in independent practice and not responsible for each others' clients. My credentials include a Doctorate in Behavioral Health and a Masters degree in counseling. I am licensed by the Arizona Board of Behavioral Health Examiners.

I offer counseling and consultation services to individuals and families in the areas of anxiety, depression, life balance coaching, self-esteem enhancement, stress management, marital counseling and divorce adjustment for children. Because my office does not have in house Psychiatric or crisis services I do not work with a serious mental illness, violent behaviors or personality disorders. If you present with these conditions, you will be referred to other professionals or programs that specialize in these areas**.** I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experience.

Financial. Payment is expected at the time the service is rendered unless other arrangements have been made. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. The fee schedule is as follows:

In addition to the basic session and assessment fees, there may be other fees for additional services such as psychometric testing, telephone counseling, books and materials, etc. The basic fees are posted in my office, and fee information for those not listed is available upon request. I reserve the right to change my fees with 30 days notice. You have the right to be informed of all fees that you are required to pay and my refund and collection policies. Please discuss these with me if you have a concern.

Fee Schedule:

Intake	$275
In Home Session	$250
In Office session	$185
Phone Consult	$185/hr
Report Preparation	$185/hr
Court Appearance	$400/hr+travel/prep
No Show/ Late Cancellation	$185/hr

Insurance. I require payment at time services are rendered. I will supply you with a superbill that you can turn in to your insurance company so they can reimburse you. In all cases however, payment for services is ultimately the responsibility of the client, not the insurance company. Your insurance company or managed care company may limit the number of sessions based on their assessment of medical necessity or other factors. Their determination may or may not match what you want or need in treatment. In the event that they will not authorize additional sessions or you exhaust the sessions that your insurance will provide, you understand that you will be responsible for self-advocating with your insurance provider.

Using a third party to pay for the counseling implies that some information will be released in order to obtain payment for the services. Please see the *HIPAA NOTICE OF PRIVACY PRACTICES* for more information.

Availability of services. **My practice does not have the capability to respond immediately to counseling emergencies.** True emergencies should be directed to the community emergency services (911) or to the local hotlines (Empact – 480-784-1500, Banner Help line - 602-254-4357, Maricopa Integrated Managed Care – 602-222-9444). Established clients with an urgent need to make contact may contact me by cellphone or email, but an immediate response is not guaranteed. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation.

Appointments. Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve an hour or more for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. Appointments for Saturday must be canceled by the prior Thursday at 5:00 P.M. ***You will be billed for appointments you fail to cancel in accordance with this policy at the full fee of $185. Repeated late cancellations or missed appointments could result in termination of services.***

Appointment availability varies with the client load at the time. High demand appointments (off hours, late afternoons, Saturdays) are likely to be sporadic in their availability. I reserve the right to limit my commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload.

Privacy, confidentiality, and records. Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statues. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved. I also participate in a process where selected cases are discussed with other professional colleagues to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods.

There are also numerous other circumstances when information may be released including when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against me, to comply with worker compensation laws, to comply with the USA Patriot Act and to comply with other federal, state or local laws. The rules and laws regarding confidentiality, privacy, and records are complex. The *HIPAA NOTICE OF PRIVACY PRACTICES,* included in this packet of information, details the considerations regarding confidentiality, privacy, and your records. This packet also contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so. Periodically, the *HIPAA NOTICE OF PRIVACY PRACTICES* may be revised. Any changes to these privacy practices will be posted in my office, but you will not receive an individual notification of the updates. ***It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.***

Purpose, limitations, and risks of treatment. Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In

the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. Of course, the potential for a divorce is always a risk in marital counseling.

Treatment process and rights. Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences or such refusal or withdrawal.

Our relationship. The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

Consent for evaluation and treatment. Consent is hereby given for evaluation and treatment under the terms described in this consent document and the *HIPAA NOTICE OF PRIVACY PRACTICES*. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature:_____ Date: _____

Credit card on file agreement.

As an authorized signer on the credit card listed below, I give Lisa Bravo and TheBravoEffect/ LisaBravo/ ParentWorx, permission to utilize the credit card for all charges related to and including services rendered by Lisa Bravo or her designee at TheBravoEffect/ LisaBravo/ ParentWorx.

I understand that this credit card will be charged for services rendered as authorized, and any and all missed or late- cancelled appointment charges.

Visa/MC Account Number: _____

Expiration Date: _____ Security Code or CID #: _____

Billing Address& Zip Code: _____

Name on Card: _____

Name of Patient: _____

Phone Number: _____

Email address: _____

_____

Signature Date

The Bravo Effect
Counseling, Coaching, Consultation
Dr Lisa Bravo, DBH, LPC, LISAC
1490 South Price Road, Suite 202
Chandler, AZ 85286

CONSENT TO RECEIVE AND/OR RELEASE CONFIDENTIAL INFORMATION

Name of Patient:

Date of Birth:

SS#:

I, _____ , herby authorize Lisa Bravo, DBH, LPC, LISAC, NCC to:

_____Receive From or _____Release To

Person/ Facility/ Insurance Co.:

Phone Number: Fax:

Address:

City, State, Zip:

Dr. Bravo may share the information indicated below with regard to the services provided to me for the periods of treatment spanning _____ to _____.

PURPOSE OF DICLOSURE

INFORMATION FURNISHED:

HISTORY_____ ASSESSMENTS_____
TREATMENT_____ CONSULTATIONS_____
DISCHARGE SUMMARY_____ PROGRESSIONS _____

OTHER (SPECIFY):

"This information has been disclosed to you from records protected by federal confidentiality rule (42 CFR, Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Parts 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

THIS AUTHORIZATION IS SUBJECT TO REVOCATION BY ME AT ANY TIME EXCEPT TO THE EXTENT AN ACTION HAS BEEN TAKEN IN RELIANCE HEREIN. IF NOT REVOKED EARLIER, IT SHALL TERMINATE AUTOMATICALLY ONE YEAR AFTER THE DATE OF MY SIGNATURE.

PATIENT: DATE:

PARENT/ GUARDIAN: DATE:

WITNESS: DATE: