

NEW PATIENT REGISTRATION
Psychological Counseling Services, Ltd.

Last Name of Patient _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Home Telephone () _____ Cell () _____ Work() _____

Date of Birth _____ Soc. Sec. Number _____ E-mail Address _____

MM DD YYYY Marital Status: Married Single Separated Divorced Widowed Other

Responsible Party Name and relationship to patient _____

Responsible Party Address and Phone Numbers _____

Patient's Employer _____ Address _____

Occupation: _____ Type of Business: _____

How were you referred: _____

Who is your first appointment with: _____

In case of an emergency, who may we contact:

Name _____ Relationship _____ Phone _____

Information Pertaining to Spouse, Partner, Children or Other

Spouse/Partner Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City _____ State _____ Zip _____

Home Telephone () _____ Cell () _____ Work () _____

Date of Birth _____ Soc. Sec. Number _____

Relationship to Patient: _____

Spouse/Partner Employer's Name & Occupation _____

Other Family Members Names and Dates of Birth:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Payment for services is due at the time of your session(s).

I/We consent to consultation and/or treatment for the above mentioned person(s):

X _____ X _____

SIGNATURE OF PATIENT TODAY'S DATE SIGNATURE OF SPOUSE, TODAY'S DATE
PARENT, OR RESPONSIBLE PARTY

PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the Notice of Privacy Practices (Psychotherapist-Patient Services Agreement) and have been provided an opportunity to read and review it.

X _____ X _____

SIGNATURE OF PATIENT TODAY'S DATE SIGNATURE OF SPOUSE, TODAY'S DATE
PARENT, OR RESPONSIBLE PARTY

INTENSIVE PROGRAM AGREEMENT FORM



Psychological Counseling Services, Ltd.

Intensive Steps to Health and Wholeness

7530 East Angus • Scottsdale, Arizona 85251 • 480-947-5739 • pcs@pcsearle.com

Re: _____
Name of participant(s)

Deposits

For Non-Emergency Services: \$1000 (U.S. Currency) non-refundable and non-transferable deposit *per week* and a signed Intensive Program Agreement Form is required to activate scheduling of your intensive program. This office accepts cash, personal check, Visa or MasterCard for non-refundable deposits only. All parties involved are required to sign an Intensive Program Agreement Form. You are required to return this agreement form signed by all involved parties.

For Emergency Services: For intensives scheduled within seven (7) days of the start date, a \$2500 non-refundable deposit (U.S. Currency) and a signed Intensive Program Agreement Form is required to activate scheduling of your program. This office accepts cash, personal check, Visa or MasterCard for non-refundable deposits only. You are required to return this agreement form signed by all involved parties.

Payments

(a) Intensive program services are cash programs. Pre-payment is required for all intensive programs. Payment in full is due at least seven (7) days prior to the beginning of each intensive week. The intensive coordinator will notify you of your schedule and the balance due. This office accepts cash, cashiers checks or money orders as payment in full. Unfortunately, we do not accept personal checks, Visa or MasterCard for these balance due payments regarding Intensive Program services.

(b) In the event that you schedule your intensive program within seven (7) days of your start date, prepayment is required in the form of a cashiers check or money order that is delivered via overnight to P.C.S. In the event that additional scheduling is done on an immediate and/or urgent basis, payment in full is required for the immediate and /or urgent additional services when ask by a PCS staff member. In the event I schedule and pay in full for an intensive to begin within seven (7) days, I understand and accept the terms even if I choose not to receive services.



By initialing this section, I affirm this policy has been clearly explained to me. _____
Initial here

Conditions/Definitions

- (1) Any outstanding balances on my account(s) must be cleared prior to the beginning of the Intensive Program.
- (2) Please review your schedule. Intensive Programs are scheduled in advance based on the selected therapist's availability. Any schedule changes requested by the client must be made at least seven (7) days prior to the beginning of your program. Once you begin the program, there are no refunds. Should you or a therapist request sessions in addition to your schedule, we will do our best to accommodate you. These add on session schedule changes must be paid for at the time the change is made-no exceptions.
- (3) Emergency Services are defined as an intensive program that is scheduled to begin within seven (7) days of the listed start date. There is a \$2500 non-refundable deposit for emergency services. No schedule changes can be made by the patient(s). Your balance due must be paid in full before any services can be performed.
- (4) Please note that once you have paid for your intensive in full, this money will not be refunded to you for any reason within seven (7) days of your start date. I accept these terms even if I choose not to receive services.

By initialing this section, I affirm the cancellation policy has been clearly explained to me and I/we have been given an opportunity to ask questions. _____
Initial here



(5) Intensive Program Insurance Waiver and Agreement::

a) This office does not assume responsibility for billing an insurance carrier for Intensive Program services. Since intensives are cash programs, the patient is responsible for billing their insurance on their own, if they choose to do so. The patient is responsible for collecting the receipts. Please note that it is recommended that you collect the receipts while you are attending the program. In the event this office inadvertently receives an insurance payment for these services, this office will redirect the payment back to the carrier and instruct them to pay the patient or insured directly.

b) The client(s) understand that they are responsible to obtain any pre-certification for Intensive services without the assistance of Psychological Counseling Services, Ltd, the professional staff members, or administrative staff members.

The client(s) understand that verification of benefits or pre-certification of services does not guarantee that an insurance carrier will cover this type of outpatient intensive services and the client(s) agree to pay for these services in advance.

(6) Information regarding participants:

1. _____
Name Date of Birth Telephone contact number

2. _____
Name Date of Birth Telephone contact number

Dates requested, please be specific: _____

(7) Each participant is required to sign and date this agreement form.

I/we agree to the terms and conditions outlined within this document.

Print your name here Sign your name here Today's Date

Print your name here Sign your name here Today's Date

If making the deposit by Visa or Master Card, please provide the following:

Visa Account Number _____ Expires _____
MM YY
Name on card _____

Master Card Account Number _____ Expires _____
MM YY
Name on card _____

If you are faxing back to PCS, please fax back both pages of this form.
The confidential fax number is 480-946-7795.

**INTAKE INFORMATION
PSYCHOLOGICAL COUNSELING SERVICES LIMITED**

Name: _____

DATE: _____ **TIME:** _____

Please fill out the information below as best you can.

DEMOGRAPHIC INFORMATION

SEX: F _____ M _____ **AGE:** _____

MARITAL/PARTNER STATUS: [Include how many years together, previous marriages, cohabitation, and briefly describe your relationship with your partner.]

CHILDREN: [Include names, ages, sex, and briefly describe your relationship with each child.]

HIGHEST LEVEL OF EDUCATION:

OCCUPATION:

ETHNICITY/RACE:

LOCATION: (Where were you raised? Where do you now live?)

REFERRAL: (Who referred you to PCS?)

RELIGION/SPIRITUALITY: (How were you raised? What do you currently practice? How important is religion/spirituality to you?)

SUBJECTIVE UNITS OF DISCOMFORT SCALE (SUDS)

Identify uncomfortable emotions you have had over the past two weeks and would like to decrease in intensity. Assign each emotion a number ranging from 0 [none] to 10 [will kill myself or have panic attacks) e.g. Depression = 8)

SUDS: 0 _____ 10

SUDS: 0 _____ 10

PRESENTING PROBLEM: [Briefly describe why you are seeking help.)

MEDICAL HISTORY:

LAST PHYSICAL: (Include any medical problems, such as thyroid, heart, blood pressure, head trauma, strokes, etc.)

EXERCISE: [Include how much and how often.)

SLEEP: [Any sleeping problems? How long?)

MEDICATION: (Include name, dose, and when taken.)

ALCOHOL USE: [How much? How often?]

NICOTINE USE: [How much? How often?]

STREET DRUG USE: (Which drug? How much? How often?)

SEXUALLY TRANSMITTED DISEASES:

ADDICTIONS: [Consider prescription drugs, street drugs, alcohol, sex, food, gambling, work, etc.)

PSYCHIATRIC HISTORY: (Include WHEN, WHERE and WHY you sought counseling and WHAT was the outcome.)

FAMILY HISTORY:

FATHER: AGE: _____ **EDUCATION:** _____

OCCUPATION: _____

ADDICTIONS: _____

RELATIONSHIP WITH YOU DURING CHILDHOOD: (Include how he disciplined you, how he showed affection, and how much time he spent with you.)

MOTHER: AGE: _____ **EDUCATION:** _____

OCCUPATION: _____

ADDICTIONS: _____

RELATIONSHIP WITH YOU DURING CHILDHOOD: [Include how she disciplined you, how she showed affection and how much time she spent with you.]

PARENTS' RELATIONSHIP: [Include how they showed affection to each other, how they resolved conflicts. Divorce? Remarriage?]

SIBLINGS: [Include education, occupation, addictions, marital status and describe your childhood relationships with each other. Do you have step- or half-siblings?]

SOCIAL HISTORY: (Briefly describe what life was like for you at each stage. What kind of student were you? Did you have – friends? What was it like at home?)

CHILDHOOD:

ADOLESCENCE:

ADULTHOOD: [Also include jobs, important relationships, education, military, family problems, religious problems, legal problems, habits, etc.]



Psychological Counseling Services, Ltd.

Intensive Steps to Health and Wholeness

7530 East Angus • Scottsdale, Arizona 85251 • 480-947-5739 • pcs@pcsearle.com

Authorization Form

480-946-7795Fax

This form, when completed and signed by you, authorizes Psychological Counseling Services, Ltd. (PCS) to release and/or request protected health information from your clinical record to the person you designate.

Re: Client/Patient Name _____	Date of Birth _____
Address _____	City _____ State _____ Zip Code _____
Phone # _____	

Name of requesting PCS Therapist: _____

I authorize Psychological Counseling Services, Ltd. to release- Please initial this section where appropriate:

- Psychotherapy Notes
- Telephone Contact/Consultation
- Psychological Exam and/or Testing Results
- Treatment Summary
- Thank You For Referral Letter/Call
- Medical Records
- PHI Only
- Other (Please be specific and detailed about your request below:)

This information should only be released TO OR FROM: (ONE PERSON/ORGANIZATION PER FORM)

Name of person, party, or agency _____		
Address _____	City _____	State/ Zip Code _____
Telephone Number _____	Fax Number _____	Email Address _____

This authorization shall remain in effect until _____ or one year from the date signed or until: _____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to PCS. However, your revocation will not be effective to the extent that PCS has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that PCS and my psychotherapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

<input checked="" type="checkbox"/> Signature of Self, Parent, or Guardian	<input checked="" type="checkbox"/> Printed Name	<input checked="" type="checkbox"/> Date signed
_____	_____	_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT (HIPAA)

This document (the Agreement) contains important information about the professional services and business policies of Psychological Counseling Services, Ltd. (PCS). It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that PCS provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that PCS obtain your signature acknowledging that PCS has provided you with this information prior to the end of your session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on PCS unless we have taken action in reliance on it; if there are obligations imposed on PCS by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you are experiencing. There are many different methods therapists at PCS may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, you should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS/SCHEDULING

We normally conduct an evaluation that will last from 2 to 4 sessions. During this time, you and your therapist can decide if he/she is the best person to provide the services that you need in order to meet your treatment goals. We define a "therapy hour" as a 45 minute appointment session. If psychotherapy is begun, you will usually schedule one 45-minute therapy session (one appointment of 45 minutes duration) per week at a time, although some sessions may be longer or more frequent. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless your therapist and you both agree that you were unable to attend due to circumstances beyond your control.] It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** [If it is possible, we will try to find another time to reschedule the appointment.] If you need to call to schedule an appointment, please call during regular business office hours of 8 am to noon and 1 pm to 4:45 pm Monday through Friday. We will not return calls to schedule appointments. Please call back during regular business office hours to schedule appointments.

PROFESSIONAL FEES

Our hourly fees range from \$90 to \$250. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if one of our therapists is called to testify by another party. [Because of the difficulty of legal involvement, we charge \$50 per hour above the therapists normal hourly fee for preparation and attendance at any legal proceeding.]

CONTACTING PCS

Due to our work schedules, we are often not immediately available by telephone. The PCS business office is open from 8am to 4:45pm Monday through Friday, except for holidays. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician, the nearest emergency room and ask for the psychologist or psychiatrist on call, or call 911. If your therapist will be unavailable for an extended time, she/he can provide you with the name of a colleague to contact at PCS, if necessary. Regarding e-mails, you may contact therapists by e-mail, however, please note that therapists will not respond to your e-mail. Do not use e-mail for emergency contact.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless he/she feels that it is important to your work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that we practice as a group with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- We also have contracts with an attorney, accounting firm, and collection agency. As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided you, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your or your legal

representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, and we are providing services related to that claim, we must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary in an attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we have reason to believe that a child under 18 who we have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that we file a report with the appropriate government agency, usually the Office of Child Protective Services and the local police department. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that we file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, we may be required to provide additional information.
- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and we believe that the patient has the intent and ability to carry out such threat, we must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not qualified attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to us by others confidentially, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of you psychotherapist, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, we are allowed to charge a copying fee of \$20 per page. If the copying of the requested records exceeds 5 minutes, there will be an additional charge of \$3.00 per every 5 minutes of time it takes to copy the requested records. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

In addition, we also keep a set of Psychotherapy Notes. These Notes are for our own use and are designed to assist us in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, our analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to your psychotherapist that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written, signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless we determine that such access is clinically contraindicated.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record (must be made in writing); requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Your psychotherapist will be happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session prior to the time it is held.

For our Intensive program, services are required to be paid in advance in full and by cash or cashiers check. For all other services, PCS accepts cash, check, Visa, or MasterCard. Payment schedules for other professional services will be agreed to when they are requested. As of October 1, 2000, this office utilizes the Check Collect[™] automated processing service for any returned checks from your bank. The bank will also automatically apply any additional fees. Delinquent accounts may be referred to a professional agency for collection and credit reporting.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

INSURANCE REIMBURSEMENT

As a general rule PCS does not accept insurance assignment. Therefore, it is your responsibility to bill your insurance company for direct reimbursement. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above [unless prohibited by contract].

(Revised May 12, 2003; updated 5/28/04, updated 8/31/04 eh, updated 03/08/05 eh)

Client Information Sheet on Therapists' Duty to Report Child Abuse or Neglect

As therapists we are legally obligated to break confidentiality and report any child or elder abuse (including physical, emotional, or sexual) or neglect.

Physical Abuse includes any action that causes:

- Impairment of a bodily function (limb, organ)
- Impairment of a physical condition or health
- Pressure sores
- Failure to thrive
- Dehydration
- Fracture of any bone
- Soft tissue swelling
- Any physical condition that imperils a child's health or welfare
- Any physical injury that creates a reasonable risk of death
- Disfigurement
- Skin bruising
- Bleeding
- Malnutrition
- Burns
- Head injury
- Injury to an internal organ

Emotional Abuse includes any action or neglect of a parent/caregiver that causes a child to experience:

- Severe anxiety, depression, withdrawal, or aggressive behavior

Sexual Abuse is engaging in sexual conduct with a minor. This includes direct or indirect touching, fondling, or manipulating any part of the genitals, anus, or female breast by any part of the body or by any object or causing a person to engage in such conduct. It also includes:

- Sexual exploitation of a child
- Child prostitution
- Furnishing harmful items to minors over the internet
- Photographing or filming a minor:
 - a. In a restroom, bathroom, locker room, bedroom or other location where the person has a reasonable expectation of privacy.
 - b. While the person is urinating, defecating, dressing, undressing, nude or involved in sexual intercourse or sexual conduct.

Neglect is when a parent/caregiver fails to provide a child with adequate:

- Supervision
- Food
- Clothing
- Shelter
- Medical care

In the event that any child abuse or neglect is disclosed, your therapist will inform you that a report must be made. *We are also obligated to release your records if we are ordered by a court to do so.* Lastly, we must take action if we believe that you may harm yourself or another person.

I have read and understand the above information regarding the duty for PCS to report any child abuse or neglect.

Client's signature

Print name

Date

Client's signature

Print name

Date

(Appendix T) (Created August 29, 2004)

Psychological Counseling Services
7530 E. Angus Drive
Scottsdale, AZ 85251
480-947-5739 Office 480-946-7795 Fax
www.pcsearle.com

Mandatory Screening Test for Dissociative Identity Disorder

Please complete the screening test for Dissociative Identity Disorder (DID). The link to complete the test is available on our website at www.pcsearle.com/screening/screen_des.html.

Once you complete the test, please print your results and include with the registration form.

Please note: We do not maintain your results on our server or in any electronic format. You cannot retrieve your results once you close your browser.

Your Name _____

Read each item below to see if it describes *how your partner usually treats you*. Then circle the number which best describes how strongly you agree or disagree with whether it applies to you. Circling a one (1) would indicate that you do not agree at all, while circling a five (5) would indicate that you agree strongly. ***Your answers are confidential and will not be shared with your partner.***

1. My partner never admits when she or he is wrong.

1 2 3 4 5
I do not I strongly
agree at all agree

2. My partner is unwilling to adapt to my needs and expectations.

1 2 3 4 5
I do not I strongly
agree at all agree

3. My partner is more insensitive than caring.

1 2 3 4 5
I do not I strongly
agree at all agree

4. I am often forced to sacrifice my own needs to meet my partner's needs.

1 2 3 4 5
I do not I strongly
agree at all agree

5. My partner refuses to talk about problems that make him or her look bad.

1 2 3 4 5
I do not I strongly
agree at all agree

6. My partner withholds affection unless it would benefit her or him.

1 2 3 4 5
I do not I strongly
agree at all agree

7. It is hard to disagree with my partner because she or he gets angry.

1 2 3 4 5
I do not I strongly
agree at all agree

8. My partner resents being questioned about the way he or she treats me.

1 2 3 4 5
I do not I strongly
agree at all agree

9. My partner builds himself or herself up by putting me down.

1 2 3 4 5
I do not I strongly
agree at all agree

10. My partner retaliates when I disagree with him or her.

1 2 3 4 5
I do not I strongly
agree at all agree

11. My partner is always trying to change me.

1 2 3 4 5
I do not I strongly
agree at all agree

12. My partner believes he or she has the right to force me to do things.

1 2 3 4 5
I do not I strongly
agree at all agree

13. My partner is too possessive or jealous.

1 2 3 4 5
I do not I strongly
agree at all agree

14. My partner tries to isolate me from family and friends.

1 2 3 4 5
I do not I strongly
agree at all agree

15. Sometimes my partner physically hurts me.

1 2 3 4 5
I do not I strongly
agree at all agree

It is important that you answer the questions accurately and honestly.

Examiner only to write below this line

Score _____

Examiner Notes:

Eating Attitudes and Behavioral Assessment

Unhealthy and/or dysfunctional eating patterns frequently accompany other compulsive behaviors. The following assessment is directed towards identifying potential problematic thoughts and/or behaviors which may be part of a greater unhealthy relationship with food and weight or which may constitute an eating disorder.

If problematic behaviors and/or attitudes are detected, a **Comprehensive Nutritional Assessment** and/or participation in our **Eating Disorder Intensive Program** may be recommended. These services are also available for those individuals who are interested in learning more about overall emotional and physical health as it relates to their experience with food and weight.

Please read each question carefully and answer either “Yes” or “No” (Y or N), accordingly.

I weigh myself on a daily basis. Y ___ N ___

My mood can go either “up” or “down”, depending on the number on the scale. Y ___ N ___

I spend a significant amount of time each day thinking about food and/or weight. Y ___ N ___

I oftentimes feel that if I could “just lose a few pounds,” my life would be much better. Y ___ N ___

I frequently compare my weight and/or appearance to that of those around me. Y ___ N ___

I am aware of my body weight and size throughout the day. Y ___ N ___

I am uncomfortable in my body. Y ___ N ___

I am frequently on a “diet”. Y ___ N ___

I frequently find myself overeating one day and “dieting” the next. Y ___ N ___

I have used the following “compensatory” behaviors to try to lose weight and/or “get rid of” calories I have consumed:

Strict dieting	Y ___	N ___
Self-induced vomiting	Y ___	N ___
Laxatives	Y ___	N ___
Excessive exercise	Y ___	N ___
Herbal supplements	Y ___	N ___
“Chew and spit” behavior	Y ___	N ___

I find myself eating when I am physically not hungry.

I find that I eat to cope with uncomfortable emotions and/or stress.

I oftentimes find myself eating in secrecy.

I think of food in terms of "good" and "bad" foods, based on their caloric or fat content.

I feel uncomfortable eating in social situations.

Other people have told me that they are concerned with my eating behavior(s).

Other people have told me that they are concerned with my weight.

To get a more complete impression of your health, it would be helpful to have the following information:

Age _____ Height _____ Current Weight _____

Highest Adult Weight _____ Age at this weight _____

Lowest Adult Weight _____ Age at this weight _____

What do you feel is your personal ideal weight? _____

Do you exercise? Yes _____ No _____

How often do you exercise? _____ times per week

If female, Are you currently menstruating? Yes _____ No _____

Are your menstrual cycles regular? Yes _____ No _____

Are you on oral contraception? Yes _____ No _____

Have you ever missed your monthly cycle (other than pregnancy)? Yes _____ No _____