General Adult and Children's Psychiatry (800) 560-1980

21043 N Cave Creek Rd., Suite A8B Phoenix, AZ 85024

Please read and complete each of the sections listed below as completely as possible.

INDIVIDUAL COUNSELING INTAKE FORMS

- Name (First, Middle, Last): _____
- Have you ever gone by any other name? If yes, please specify:
  _____
- Date of birth: _____ Sex: M / F Marital Status: _____
- Street Address: _____
  City: _____ State: _____ Zip: _____
- SSN: - - Email address: _____
- Phone Numbers (Please check the box if able to leave a detailed message):

  ☐ Home: _____ ☐ Work: _____ ☐ Cell: _____

Medical and Referral Information

Name of Primary Care Physician: _____

Telephone Number of Primary Care Physician: _____

Address of Primary Care Physician: _____

May I contact your health care provider in the future? Yes No

Who referred you to our practice? _____

Please list names and contact information for any doctors and/or therapists that have been significantly involved in your care over the last ten years.

_____

_____

_____

Emergency Contact

Who should we contact in case of emergency? _____

Relationship to you? _____ Phone number _____

Medical History

Current medical problems (please include date of onset):_____

_____

Past medical problems and/or surgical history (with dates): _____

_____

Past mental health treatment/couples counseling (location, dates, provider names, and any other relevant information):

_____

_____

Family Medical/Mental Health/Drug/Alcohol History (siblings, parents, children, aunts/uncles):

_____

_____

Current medications (name/dosage/frequency/reason for taking the medication):

_____

Past psychiatric medications (name/dosage/frequency/reason for taking the medication):

_____

_____

Allergies to medications and reaction: _____

Supplements, vitamins, or herbs: _____

Drug or alcohol use (include amount and frequency): _____

_____

Do you currently use tobacco: Yes, No If yes, how long? _____

Have you ever used tobacco in the past? Yes, No If yes, please specify: _____

Exercise (frequency & type): _____

Present Issues

Symptoms and duration:

Authorization to Release Patient Health Information for

Treatment, Billing, or Healthcare Operations

I understand that Clearview Health reserves the right to change their notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand that I may revoke this consent in writing. I understand that the Clearview Health staff are not required to adhere to these restrictions requested in the event of a potentially life threatening emergency.

Records may be needed in order to process a claim for mental health services. I authorize providers at Clearview Health to release information needed for billing purposes to entities that may provide services pertaining to my visit. I understand that by signing below, I am authorizing the release of all or part of my record for the purpose of billing, treatment, or pertinent healthcare operations.

Patient/Guardian Signature_____ Date_____

Patient/Guardian Printed Name_____

I authorize Clearview Health to discuss my mental health care to any and all past or present treating health professionals as well as the following (*please list* any friends or family members that you may want to have included in your treatment):

_____

I am aware that this information may pertain to my mental health condition and/or treatment of substance abuse. I execute the release of this information.

Patient/Guardian Signature _____Date_____

Patient/Guardian Printed Name_____

Agreement for Service / Informed Consent

This agreement has been created for the purpose of outlining the terms and conditions of services to be provided by Therapist for _____(herein "Client") and is intended to provide important information regarding practices, policies and procedures of Therapist, and to clarify the terms of the professional therapeutic relationship between Therapist and Client.

Psychotherapy is a process that involves the Therapist, the Client, and sometimes other family members as well. During the process, a myriad of issues, events, experiences and memories are explored for the purpose of creating positive change so Client can experience life more fully. It provides an opportunity to better, and more deeply understand oneself, as well as any problems or difficulties client may be experiencing. Psychotherapy is a joint effort between the Client and Therapist that requires an active participation in the therapeutic process, honesty, and a willingness to take in feedback on the part of the client.

Benefits and Risks of Therapy: Since therapy often involves discussing many aspects of Client's life (both positive and negative), Client may experience uncomfortable feelings, which can be difficult. However, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There is no guarantee that you will experience all of these benefits. You are encouraged to address any concerns you have about your treatment with your therapist.

Privacy and Release of Information

The information disclosed by the Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law listed below:

- Threats of harm to yourself of others
- Abuse of a vulnerable adult, child, or developmentally disabled person
- A court order to release information
- Subpoena of treatment records by an attorney. If you do not want this information released, you must obtain a protective order from the court within fourteen days of the request.
- If you will be submitting a claim to your health insurance, we may be required to prove information to your health plan, including some or all of your record of treatment, in order for your carrier to pay for services. By signing this form, you consent to release this information to your health plan.
- If you are involved in a child custody litigation at any time in the future, the court may order release of information about your treatment

In circumstances other than these, I will not release information about your treatment without your authorization.

Notice of Office Policies and Procedures

Patient Records

A secured electronic record is kept of services you receive in this office. You have the right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize, in writing, that copies of the record be released to entities you designate. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider.

Methods of Communication and Execution of Clinical Care

You can generally expect a return call within two business days that a message is left. Should there be an emergency or concern for imminent health or the safety of yourself or another person, please call 911 or go to the nearest emergency room immediately.

Hospitalization

Should you require hospitalization, please go to your nearest emergency room or dial 911. Staff at Clearview Health do not have admitting privileges at the hospital. Should you need to be admitted, they can communicate with the inpatient treatment team to let them know about your prior treatment.

Consent for Additional Services

Consent for Tele therapy:

Providers can use video conferencing to see clients, should that be the best option for the therapist and client. Please keep in mind that this is up to the discretion of the provider. Also, please note that if you plan to submit your superbill to your insurance company for reimbursement, they may not reimburse as much as they would if you were seen in the office.

Patient/Guardian Signature_____ Date_____

Patient/Guardian Printed Name_____

Consent for Secure Messaging:

Patients are offered the opportunity to use secure messaging (similar to email) with providers through patient fusion. Should a patient elect to do this, please keep in mind that this service should only be used for non-emergent matters as messages are not checked daily. This service is HIPAA compliant.

Should there be an emergency, the best option is call 911 or go to the nearest emergency room.

Patient/Guardian Signature_____ Date_____

Patient/Guardian Printed Name_____

Consent for Email and/ or Text Messages

I understand that Clearview Health cannot guarantee the confidentiality of any email communications and will not be liable for improper disclosure of confidential information and/or breaches in confidentially caused by me or a third party. I understand that Clearview Health has no control over the security or management of my individual email service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient. I further understand and agree that: email will not be used in emergencies and I agree to call 911 in the event of an emergency, emails will be answered within a maximum of 7 business days and that a prompt reply may not be available during weekends or holidays, I must include my full name and date of birth in every email message I send, I understand and agree that providers may choose to stop electronic communications with me at any time, and I understand that the confidentiality of my individually identifiable health information may be compromised when such is sent through email. I agree to the requirements listed above and hereby voluntarily request and consent to communicate with therapist and/or office personnel by email or text.

Patient/Guardian Signature_____ Date_____

Patient/Guardian Printed Name_____