David C. Brown Ph.D.
1744 E. Fountain Street
Mesa, Arizona 85203
480 641-9700 office
480 641-9751

PERSONAL INFORMATION **(Please Print Clearly)** **Today's Date** ____/____/____

Client Name: ______________________________
Last First Middle

Address: ______________________________
Street City State Zip

Phone: (____) __________ Landline (____) __________ Work (____) __________ Cell

Date of Birth: __________ Religion: __________

Marital Status:
[ ] Single [ ] Divorced [ ] Separated [ ] Widowed
[ ] Married-Name of Spouse: __________ Ph# __________

Employment Status:
[ ] Full-time [ ] Part-time [ ] Domestic Engineer [ ] Student [ ] Retired [ ] Unemployed

Employer: __________ **E-MAIL ADDRESS** __________

Job Title: __________ **Description of duties:** __________

How many hours do you work per week? __________ **Which shift?** __________

If Client is under the Age of 18, Please Complete the Following:

Grade: __________ Name of School: __________ Principal: __________

Responsible Party/Insurance Provider Information (Please Print Clearly)

Responsible Party: __________ SS# __________ D.O.B.: __________

Policy Holder: __________ SS# __________ D.O.B.: __________

Address if different from above: __________

Insurance Company: __________ Policy #: __________ GRP#: __________

Billing Address: __________ Phone: (__) __________

Note: Verification of benefits is not a guarantee of payment, but is just a summary of the benefits available. Final determination is made upon receipt of the claim and review of all documentation.

Client relationship to the Insured: [ ] Self [ ] Child [ ] Spouse [ ] Other: __________

Clinician Signature: __________ Date: __________ Dr. David C. Brown, Ph.D., LMFT-0148

CLIENT BACKGROUND INFORMATION

Please list the persons with whom you are currently living with how they are related to you. Also, please list any immediate family members (children/step-children, spouses, etc) that are *not* living with you, if applicable:
If you are divorced, what are the custody arrangements, ie: joint or shared?______________

Name	Relationship	Age

CLIENT HEALTH HISTORY INFORMATION

Family Physician______________________________ Phone:______________________

Current medical problems:____

Allergies:____

In case of emergency, please notify:_______________________________________

How did you hear about my practice?:______________________________________

Presenting problem and reason for referral?:__________________________________

Why are you seeking help now:?:____

Have you currently or previously sought professional counseling or psychiatric consultation? Yes_______ No______
(If "yes". Please state the name of the mental health professional/s and the date/s of treatment)____

Have you ever been hospitalized for a mental health condition? Yes_______ No_______ If yes, please explain:
____

Clinician Signature:_________________________________ Date:________ Dr. David C. Brown, Ph.D., LMFT-0148

Date: ____________

Are you currently taking any medication on a daily basis: Yes______ No________ If yes, what is/are the name/s and dosage of the medication? ____

Do you have any health conditions that adversely impact you daily routine? Yes____________ No____________

(If "yes", please explain): ____

Do you currently have suicidal thoughts? Yes____________ No______________ Unsure____________

Have you previously had suicidal thoughts? Yes____________ No______________ Unsure____________

Have you ever attempted to commit suicide of self-Injure yourself (i.e. cut, burn, etc.)?Yes________ No________

(If "yes", please explain what happened): ____

____

____

____

Do you currently have thoughts of wanting to seriously harm or kill someone? Yes____________ No____________

Do you currently experience drug or alcohol problems? Yes______________ No______________

Have you previously struggled with drug or alcohol issues? (circle one) Drugs Yes or No--- Alcohol Yes or No

Have you ever as a child or adult, been a victim of physical or sexual abuse? Yes______ No_______ Unsure______

Are you currently being abused?

Yes, Physical____________ Yes, Sexual___________ Yes, Emotional___________ No__________ Unsure_________

Are you currently involved in any form of litigation? (i.e. court proceedings)"Yes____________ No____________

(If "yes" please explain): ____

____

____

Have you ever been arrested for any civil or criminal action? Yes__________________ No______________

Comments? ____

____

____

____

Clinician Signature: ________________________________ Date:________ Dr. David C. Brown, Ph.D., LMFT-0148

Please Circle Any of the Following Problems Which Pertain to You:

If under 18 years old, please disregard the following and complete the "Child/Adolescent Assessment Supplement" Form, which is the next page.

Name ______________________ Date ______________

Nervousness
Shyness
Marital Separation
Drug Use
Anger
Sleep
Relaxation
Anxiety
Legal Matters
Energy
Loneliness
Education
Finance
Work
Ambition/Motivation
Marriage

Temper
Children
Stomach Problems
PMS
Difficulty Sleeping
Sexual Dysfunction
Physical Abuse
Sexual Abuse
Alcohol Abuse
Self Control
Stress
Friends
Tiredness
Decision Making
Bowel Problems
Depression

Headaches
Memory
Insomnia
Inferiority Feelings
Career Choices
Nightmares
Appetite
Being a Parent
Divorce
Fears
Suicidal Thoughts
Unhappiness
Concentration
Health Problems
My Thoughts

Deseret Counseling Center

1744 E. Fountain Street Mesa, Arizona 85203
480 641-9700

Client Information and Office Policy Statement
Informed Consent

I. New Client: Welcome!

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.

II. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.

2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.

3. Identifying personal treatment goals.

4. Promoting wholeness through psychological growth. You are responsible for providing necessary information to facilitate effective treatment.

You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s). You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

Initials: ____________________

III. Appointments:

Appointments are usually scheduled for 50 minutes. Office hours are Mon-Friday, 10:00AM to 8:00 PM. Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, if you are unable to reach your therapist, you may call your primary care physician or the local emergency room, or a crisis hotline or 911.

Initials: _____________

IV. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:

1.) Suspected abuse or neglect of a child, elderly person or a disabled person, 2.)When your psychiatrist or therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3.) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4 You may be asked to sign a Release of Information so that you therapist may speak with other mental health professionals or to family members.

Initials: ______________________

V. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Because my intake and progress records contain information which can be misinterpreted by someone who is not a mental health professional, if you request your records which are maintained by me, it is my preference that you accept a verbal or written summary of their content, in lieu of my entire record. However, you are entitled to request and receive my entire record, unless I believe that to do so could be physically or emotionally damaging to you. Also, if you request, I will provide free of charge, a brief telephonic summary to another appropriate mental health professional with whom you are working. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. If you request a written summary, there will be an additional charge. Medical records are locked and kept on site. In accordance with ARS 12-2297, records are retained for a period of six years after the date of the patient's/client's discharge/termination of therapy. For a minor, the records are retained for three years after the patient/client reaches eighteen years of age for six years after the date of the patient's/client's discharge/termination of therapy, which ever date occurs last.

Initials: ______________________

VI. Fees:

Fee for the initial visit is 160.00 each 45-50-minute session. We accept cash, check or debit If you have insurance with a company we are contracted with, you will only be responsible for your deductible (if applicable) and co-pay/co-insurance. If, however, your insurance fails to pay, you will be responsible for the entire billed amount. Court related issues are charged at $300.00/hr. Insurance companies will not be billed for any services that are court/forensic in nature. A retainer may be required prior to your first visit. Court testimony, legal opinions, depositions, prep time and travel time (door to door) are $350.00 per hour.

Initials: ______________________

VII. Payments:

Payment is due at the time of the session unless other arrangements have been made. Our office will assist you in determining your benefits and file your insurance claim, however, you are responsible for calling your insurance/EAP company to determine deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefits. In the event your insurance company

fails to pay a claim you are responsible for the entire billed amount. Signing this form also authorizes payment of medical benefits to the Mental Health Professional of supplier of services.

Initials: ____________________

VIII. Cancellations and Missed Appointments:

You must cancel or reschedule your appointment by noon the business morning prior to your scheduled appointment. If your appointment is on Monday, you will need to contact our office on the morning of the previous Friday no later than noon. If you have an emergency and are wishing to reschedule with less notice than the business morning prior, and we are able to accommodate you with a different appointment within the same week, you will not be charged the no show/late cancel fee of $160.00. "No Shows/late cancels" are billed at the $160.00 rate. You may leave messages 24 hours per day. In the event we are not able to re-schedule your appointment, you will be billed $160.00 --not just a copayment. Insurance will not be billed for missed appointments.

Initials: ____________

Please supply us with the following information that we may use to charge in case of a Late Cancel or No Show: Please indicate the card type: _______Visa _______MasterCard Name as it appears on the card: ____

Credit Card ____ ____ ____ ____/____ ____ ____ ____/____ ____ ____ ____/____ ____ ____ ____

expiration__________ CCV ________

Billing address your statement goes to ____
City___________________________ State_________________ Zip Code_________________

Do you want this card charged for all visits as well? __________ Yes __________ No

IX. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose. Initials: ______________________

X. Consent for Treatment

By signing below, you are stating that you have read and understood this 3-page policy statement and you have had your questions answered to your satisfaction. This is also authorization to release any medical or other information necessary to process your insurance claim. Initials: ______________

XI. Limited release of information:

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses & disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office, instead of the individual's home.

Please indicate in which manner you wish to be contacted (check all that apply):

Home phone: ____________________

_____Ok to leave a message with detailed information

_____Leave a message with call-back number only Work phone: ____________________

_____Ok to leave a message with detailed information

_____Leave a message with call-back number only Written communication:

_____Ok to mail to my home address

_____Ok to mail to my work/office address

_____Ok to fax to this number_______________

_____Other: ______________________________

Additionally, if the individual has a spouse/partner, family member or caregiver with whom they live or rely on and may want to have them be able to have knowledge of certain information, i.e., appointment dates/times, insurance/billing information, etc. Please let us know any persons that we may be able to discuss limited information just mentioned, that may or may not be part of your counseling session with Dr. Brown.

Name: ____

Information allowed to be shared:

____

(This authorization may be revoked at any time upon your written request)

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of patient :(please print) ____

Signature: ____

Date: ____________________

Therapist/Witness: ____

If this is a joint or family session please sign if permission is given;

I ______________________________authorize any information that pertains to me in this chart or during our session, to be shared with ____________________________________.

Signature: ____Date_______________