

DESERET COUNSELING CENTER

DR. 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 Name: _____

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.

<u>Name</u>		<u>Date</u>
Nervousness	Temper	Headaches
Shyness	Children	Memory
Marital Separation	Stomach Problems	Insomnia
Drug Use	PMS	Inferiority Feelings
Anger	Difficulty Sleeping	Career Choices
Sleep	Sexual Dysfunction	Nightmares
Relaxation	Physical Abuse	Appetite
Anxiety	Sexual Abuse	Being a Parent
Legal Matters	Alcohol Abuse	Divorce
Energy	Self Control	Fears
Loneliness	Stress	Suicidal Thoughts
Education	Friends	Unhappiness
Finance	Tiredness	Concentration
Work	Decision Making	Health Problems
Ambition/Motivation	Bowel Problems	My Thoughts
Marriage	Depression	

Client Name: _____

Date: _____

CONFIDENTIAL

CHILD/ADOLESCENT ASSESSMENT SUPPLEMENT

(Please Check All That Apply)

Developmental Irregularities

- Prenatal Difficulties
- Problems During Delivery
- Maternal Substance Use or Illness During Pregnancy
- Toilet Training
- Motor Development/Coordination
- Walking
- Language (Speech, Comprehension)
- Growth (Height, Weight)
- Socialization
- Sleep
- Eating
- Sexual Development/Puberty
- Other _____

Health/Physical Problems

- Hereditary Health Problems
- Seizures, Fainting, Neurological Problems
- Physical Impairments
- Chronic Health Problems
- Hospitalization, Surgeries
- Serious Illness
- Head Injuries
- Other Serious Injuries, Accidents
- Prone to Infections
- Long-term Use of Medications
- Exposure to Toxins
- Visual or Hearing Impairments
- Other _____

Environmental Factors

- Physical Abuse or Neglect
- Emotional, Verbal Abuse
- Lack of Stability, Excessive Disruptions
- Substance Abuse in the Family
- Poverty (Exposure to Crime, War)
- Other _____

- Sexual Abuse
- Significant Losses, Separations
- Family Discord, Tension
- Violence in the Family
- Severe Family Illness

Symptomatic Behavior

- Running Away
- Aggressive, Bullying, Emotional Cruelty
- Destructive Behavior, Vandalism, Fire-Setting
- Cruelty Toward Animals
- Problems Getting Along with Peers
- Behavior Problems at School (Fighting, Truancy, Discipline Problem)
- Defiant, Hostile, Resistant, Rebellious
- Gang Association, Other Undesirable Associations
- Cheating, Lying, Stealing, Shoplifting
- Lack of Foresight, Judgment
- Fidgety, Restless, Overexcited
- Problems with Attention, Concentration Memory, Organization
- Difficulty Understanding/Following Instructions
- Difficulty Completing Tasks, Jumping From One Activity to Another
- Learning Difficulties, Poor Grades
- Low Frustration Tolerance, Impatient, Tantrums
- Poor Impulse Control, Excessive Risk-Taking
- Feelings Easily Hurt, Easily Discouraged, Cries Easily
- Excessively Self-Critical, Self-Deprecating, Self-Conscious
- Suicidal Talk/Gestures/Pre-Occupation with Death
- Lack of Motivation or Interest, Underachiever
- Moody, Irritable
- Lack of Energy, Lethargic, Excessive Sleep
- Eating Problems, Weight Gain or Loss
- Bedwetting, Enuresis, Encopresis
- Nail-Biting, Thumb-Sucking, Tics, Twitches

- Nightmares, Sleep Problems
- Excessive Fears, Phobias
- Anxious, Worried, Fretful
- Perfectionistic, Obsessive-Compulsive Behavior
- Excessive Dependency, Need for Reassurance
- Inappropriate/Excessive Attention-Seeking
- Pre-Occupation with Illness, Health
- Excessively Timid, Shy
- Excessive Day Dreaming, Losing Time
- Few or No Friends
- Detached, Indifferent, Unaffected By Events
- Withdrawn, Isolative, Reclusive
- Mentally Dull, Slow, Little Imagination
- Socially Inappropriate or Peculiar Behavior
- Inability to Distinguish Fantasy from Reality
- Unusual or Bizarre Thinking
- Alarming Drawings/Writings
- Self-Mutilation/Abuse
- Inappropriate Sexual Behavior
- Known or Suspected Substance Abuse
- Unpredictable Changes in Mood or Behavior
- Drastic Changes in Appearance or Hygiene
- Accident-Prone
- Gender Identity Problems
- Other _____

Clinician Signature: _____ Date: _____

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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-Thursday, 10:00AM to 6:00 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 your 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, whichever date occurs last.

Initials: _____

VI. Fees:

Fee for the initial visit is 180.00 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 \$180.00. "No Shows/late cancels" are billed at the \$180.00 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 \$180.00 --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 _____