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Azure Bay Psychotherapy
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CONFIDENTIALAITY - OFFICE PROCEDURE AND FINANCIAL AGREEMENT, INTAKE FORMS AND PERSONAL INFORMATION

Please Print all five pages of these forms, sign and date them where indicated, and bring them to your first counseling appointment. If you cannot access these forms or would prefer to fill them out in my office please plan to arrive at least 15 to 20 min. before your appointment time and I will leave the forms in my waiting room for you to fill out before our session.

Azure Bay Psychotherapy is a business facility where a number of mental health professionals practice. Each therapist is an independent practitioner. The name *Azure Bay* is for the purpose of shared office expenses. Your contract for services is with your therapist only and does not include a contract with any of the other therapists at this site.

RIGHTS AND RISKS:

- Please feel free to ask questions about any aspect of counseling.
- You want to be willing to discuss anything that troubles you and to be open to change.
- You may remember unpleasant events, arouse intense emotions, and/or alter close relationships.
- If you have been referred by a court or agency, you have the right to share only what you want included in a report.

CONFIDENTIALITY

- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- Information shared will be held in confidence.
- I am required by law to disclose information related to suspected child abuse, the inability to care for one's basic needs, and threatened harm to oneself or others.
- The courts can subpoena counseling records.
- Information regarding treatment and diagnosis may be provided to an insurance company.
- You may want to discuss further limits or exceptions regarding confidentiality.

APPOINTMENTS

- All office visits are by appointment and will be scheduled through your therapist.
- The usual length of an appointment is 50 minutes.
- Late cancellations (less than 24 hours before the appointment) and/or no-show appointments are billed to the client for the full amount.
- If your appointment is cancelled or missed contact the therapist for a new appointment time.
- Insurance companies will not pay for no-show charges or late cancellation charges, or for telephone consultations.

FEES

- You are responsible for the fee at the time of your visit unless other arrangements are made with the therapist.
- Your insurance may cover some of your counseling costs.
- It is your responsibility to find out if your policy requires preauthorization for services.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable

FINAICIAL POLICY

I am not on many insurance provider lists, but some insurance companies have an "out of network" provision. You can check with your insurance company to see if they will reimburse you for counseling services. I do not do insurance billing, but am happy to provide you with the correct billing information and forms that you can send to your insurance company.

Payment is required at the time of service or you may choose to be billed once a month.
In the case of the second option you are required to keep your bill paid in full every month.

My present fee for new clients is $90.00 an hour.

Phone consultations lasting more than 10 minutes will be billed at the regular hourly fee.

Please sign on the following line that you have read the information provided on this page, as well as on the previous page and that you understand and agree to the policies described here.

Client's Signature_____Date_____

Parent or legal guardian when needed_____Date_____

PERSONAL INFORMATION

Full Name_____

Date of Birth_____**Age**_____

Address_____ **Home or Cell phone**_____

_____ **Work Phone**_____

_____

Referred by_____

Employed by_____

Social Security Number_____

Emergency Contact_____**Phone#**_____

Last Physical Exam_____ **Physician**_____

Serious illnesses in the last five years_____

Please indicate if you are willing to have messages left on your home or cell phone

YES_____**NO**_____

Please indicate if you are willing to have messages left on your work phone

YES_____**NO**_____

BIOPSYCHOSOCIAL HISTORY

PRESENTING PROBLEM
Please describe what is bringing you to psychotherapy at this time in your life.

Current Symptom Checklist
Although all of these symptoms can be familiar in one form or another please circle those symptoms that are most intense for you right now.

depressed mood	appetite disturbance	sleep disturbance	fatigue/low energy
poor concentration	mood swings	agitation	emotionality
generalized anxiety	panic attacks	obsessions/compulsions	phobias
bingeing/purging	anorexia	aggressive behaviors	elevated mood
hyperactivity	self-mutilation	medical condition	substance abuse
grief	hopelessness	social isolation	destructive thoughts

Treatment History

Prior outpatient psychotherapy
Yes No
When and for how long_____

Prior inpatient treatment
Yes No
When and for how long_____

Current psychotropic medications
Yes No
Please list name of medication and amount_____
Physician_____

Family History
Are your parents still alive? _____

Do you have siblings? _____Older _____Younger_____

Are you married? _____

Do you have any children? _____age and sex_____

Are you in a relationship? _____

How many people live in your household at this time? _____

NOTICE OF PRIVACY PRACTICES

CONFIDENTIALITY AND YOUR HEALTH CARE INFORMATION

If you are using insurance for part of your coverage for therapy it is important for you to know that there are limited circumstances in which I might need to provide information about your health to your insurance company.

Information about you is used to provide your insurance company with an evaluation and a diagnosis related to your treatment. You are welcome to examine those forms at any time. It is generally my practice to discuss any diagnoses that goes to your insurance provider with you before these forms are completed.

Any other sharing of information regarding your therapy is done only when you have signed a "release of information" form. It is your privilege to determine when, and with whom; information about your treatment is discussed. Your confidentiality is always protected as defined above.

The following list outlines your information rights:

1. You have the right to know how I use your health information.
2. You have the right to restrict uses and disclosures regarding your health information.
3. You have the right to confidentiality.
4. You have the right to have a copy of any insurance information regarding your care.
5. You have the right to have your material amended if I agree it is inaccurate or incomplete

Please sign below that you have read this form as a Notice of Privacy Practices.

Signature_____Date_____