Stacey Bruen, MC, NCC, LPC

9929 North 95th Street, Suite 101 • Scottsdale, AZ 85258 • (480) 948-1123

Full Name: _____

Patient (if other than above):_____

Patient Date of Birth: _____Referred by:_____

Address:_____City/State: _____Zip: _____

Home Phone:_____ Cel Phone:_____ Work Phone:_____

Email:_____

Informed Consent for Assessment and Treatment

Welcome to my counseling practice. I am committed to getting you whatever your outcome is for our time together. A counseling situation offers a unique relationship between the two of us. Therapy has the ability to allow one to process, grow, and heal. I am a professional counselor in an independent private practice. My credentials include a Masters Degree in Counseling Psychology, and I am licensed by the Arizona Board of Behavioral Health Examiners. In addition, I am a certified by the National Board of Certified Counselors as a National Certified Counselor and I am a Board Certified Professional Counselor through the American Psychotherapy Association.

I offer counseling, psychotherapy, and coaching services to individuals, children/teenagers, couples, and families in the areas of mental health, relationships, adjustment, personal development, family transition (i.e. divorce), parenting and skill development issues. I utilize an eclectic approach to therapy geared towards self-improvement and personal growth through challenging and often tragic times. I employ therapeutic techniques and interventions that specifically cater towards each individual, couple, or family.In order that we start our relationship in a healthy way, I have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling and psychotherapy services.

Purpose, limitations, and risks of treatment. Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that could result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. I value my approach to pro-active therapy. Treatment plans and goals will be discussed and a plan of action will be established.

Treatment process and rights. Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences or such refusal or withdrawal.

Privacy, confidentiality, and records: Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. I will not be used to testify in legal matters related or unrelated to therapy. I also ask by signing this form, you will not be requesting records for use in Court or other legal matters, such as divorce or litigation.

- **This counselor will *not* be used to testify in legal matters related or unrelated to therapy.**
  Signature _____
- **I also agree, there will be no recording of sessions.** ***Signature*** _____

I also participate in a process where selected cases are discussed with other professional colleagues to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods.

During times when I am out of town or otherwise unavailable, I will typically have another licensed therapist on call for me. I reserve the right to disclose confidential information from your records and our time together, including personally identifiable information, to this on-call therapist to facilitate the coverage of your care in my absence.

Availability of services: My practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to the local hotlines (Empact – 480-784-1500, Banner Help line - 602-254-4357, ValueOptions – 602-222-9444). I attempt to return phone calls within the same day if left during office hours or within a 24/48 hour period. Also, **I do *not* communicate via email.** Once you are an established client, you may schedule/cancel/re-schedule appointments via text message (same cancelation policy applies). I will respond to each text. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation. If you do not get a response from me, you can assume I did not receive your text. Remember: It is not in my practice to do any type of therapeutic communication/counseling via text message…appointment scheduling only.

I understand that texting/emailing is not confidential. ***Signature*** _____

Appointments/Financial: There are sometimes misunderstandings about the length of sessions. Therapy sessions, as defined by the American Medical Association Current Procedural Terminology coding, are 45minutes, not one hour. This is known as a "therapeutic hour." Longer appointments are sometimes useful and can be scheduled if you let me know you would like to do this ahead of time. Please note that some insurance companies will not pay for an appointment outside of the traditional 45 minutes.

Payment is expected at the time the service is rendered. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. The fee for a 45 minute individual session, family, couples, Court ordered, or parenting session is $195.00. All intake sessions will be billed at $225.00. Telephone sessions versus in-office sessions are billed at the regular session fee. Time spent providing special services, such as document reviews, telephone time, case consultations, and time spent discussing treatment with other professionals are billed at $50 per 10 minutes. Additional time added to the clinical session will be billed at the same additional rate. Refunds are not made after the services have been rendered.

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve a 45 minutes for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Tuesday through Friday) prior to your appointment if you need to cancel. Appointments for Mondays must be canceled by the prior Friday at 3:00 P.M. All appointments considered after school/work, appointments 3:00pm or later must be canceled by 3pm the previous day. I do not initiate reminder phone calls. You will be billed the full rate ($195.00/$225.00) for appointments you fail to cancel in accordance with this policy and your credit card may be charged. Please note that these

are personal financial obligations that <u>you</u> are responsible for; not the obligations of your insurance company.

I understand the cancelation policy. Signature ___________________________

Insurance. I am not a preferred provider for health plans in this locality. If you are using one of these plans to pay for your treatment it would be your responsibility to call your insurance company to find out your mental health benefits. If you are using an insurance program, I will supply you with a superbill that you can turn into your insurance company so they can reimburse you. Your insurance company or managed care company may limit the number of sessions based on their assessment of medical necessity or other factors. Their determination may or may not match what you want or need in treatment. In the event that they will not authorize additional sessions or you exhaust the sessions that your insurance will provide, you understand that you will have to pay for the additional services rendered. All services are payed immediately following the therapeutic session. In all cases however, payment for services is the responsibility of the client, not the insurance company. Once again, please discuss this with me if you have any questions.

Phone Contact. I have a strong preference to face-to face contact when doing counseling. I believe that personal contact facilitates a greater depth of understanding and makes our time together more productive. However, there may be times when some limited telephone counseling is warranted. Telephone counseling should be scheduled for a mutually agreeable time and will be billed at $50.00 for each 10 minute period of counseling. If a "session" (45-minute) is scheduled, the full session fee will be charged. After a release is signed, phone consults with other professionals may be required. These consults/collaborations will be billed at the same rate: $50 per 10 minutes of time.

Appointment availability varies with the client load at the time. High demand appointments (off hours, late afternoons, late evenings, etc.) are likely to be sporadic in their availability. I reserve the right to limit my commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload.

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Consent for evaluation and treatment: Consent is hereby given for evaluation and treatment under the terms described in this consent document. I acknowledge that I have printed a copy of this informed consent agreement for myself. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature: ____ Date: _______________

In the case of a minor child, please specify the following:

Full name of minor : _________________________ DOB ________ Relationship: __________

Signature: ____ Date: _______________

Signature: ____ Date: _______________

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Information Pertaining to Person Financially Responsible

Full Name: _____

Patient (if other than above):_____

Patient Date of Birth: _____Referred by:_____

Address: _____City/State: _____Zip: _____

Home Phone:_____ Cel Phone:_____ Work Phone:_____

Email:_____

Office Policy and Financial Responsibility Statement

I UNDERSTAND THAT:

- Sessions are **45 minutes** in length and are billed at **$195.00 per session** for all counseling sessions. ***All intake sessions will be billed at $225.00.*** Sessions of late arrivals will end on time.
- *Parents/Guardians who provide transportation are required to stay at the office while their young child(ren) are being seen. If a parent/guardian is late for pick-up of a teen, I understand my child/teen will be waiting in the reception area.*
- The rate of $50.00 per 10 minutes will also apply to time spent providing special services, such as telephone sessions, phone calls, document reviews, or case consultations, and time spent discussing treatment with other authorized professionals. Additional time added to the clinical session will be billed at the aforementioned rate. **+This counselor does not communicate via email or participate in any type of therapy over text communication.**
- Due to confidentiality with technology, if set boundaries are crossed and this counselor receives continual emails or therapy information via text (after a warning), a $25 charge per email/text will apply.
- Stacey Bruen does not participate with third party payers, such as managed care organizations and insurance companies. By signing this form, I am agreeing to pay the entire bill at the time of service. If requested, I may receive a "super-bill" as a receipt to submit to a third party payer. There are no-refunds.
- ****Monday** appointments must be cancelled by Friday at 3:00pm; 3:00PM or later appointments must be canceled by 3:00PM the previous day; and for all other appointments, I must give 24 hour notice of appointment cancellation or I will be billed IN FULL for "no show" or late cancelled appointments and my credit card on file may be charged.**
- Payment of cash, check or credit card is expected at the end of each visit. If you choose to pay with a credit card, a 3.3% transaction processing fee will be assessed to each transaction. I understand my credit card may be charged for late canceled appointments/noshow **signature: _____**

Credit card #_____ Expiriation:_____ 3/4 digit code_____ Zip_____

Please note that if Stacey Bruen is not available, you can leave a message and your phone call will be returned, although this may take 24 - 48 hours. In the event of an emergency, please do not hesitate to call 911 or to go to the closest emergency room or call local hotlines such as Empact, Banner Help Line, and Value Options listed on your Informed Consent Form.

I understand that I am financially responsible for any and all charges incurred for the treatment of the above-named. I have read the above office policy regarding length of sessions, late arrivals, charges, missed appointments, etc. **I understand and agree to the stated terms.**

_____ _____

Signature of Client (or Parent of Minor child) Date

Child/Adolescent Questionnaire

(To be completed by the Parent or Guardian)

The purpose of this form is to obtain a history of your child's life. The information you are able to provide will assist us in better understanding your child.

Please answer all questions. If a question does not apply, write "does not apply." Some of these questions may require considerable thought before answering. Please describe and explain the situation as it is and avoid the use of words such as average, normal, and good.

Child's Name:	Birthdate:	Sex:
Birthplace:	School Name:	Age: Grade:

FAMILY	NAME	AGE	EDUCATION COMPLETED/ CURRENT GRADE
FATHER			
MOTHER			
STEP-PARENTS			
BROTHERS			
SISTERS			

NAMES AND PLACES WHERE CHILD HAS PREVIOUSLY BEEN TREATED

PERSON	NAME OF PLACE	PREVIOUS DIAGNOSIS

Describe, in your own words, your child's present challenge(s). Include when it began and what you think has caused it.

Describe any previous difficulties your child has had.

Describe your child's strengths.

What does your child like best?

Of what is your child afraid?

Describe how your child gets along with other children, including siblings/step-siblings.

Describe how your child behaves with you.

Describe any physical problems or serious illness your child has had.

List any medications your child takes (include dosage amount).

-Explain the reason for the medication.

-How long has the medication been taken?

- Who monitors the medication?

Describe any challenges or conditions other children may have in the family.

To what extent has your child been cared for by others (past and present)? Who? When? Where? (In your home, child care facilities, or elsewhere)?
Is the child from your present relationship? YES or NO

-If not, how would you describe the child's relationship with the other parent?

Is your child adopted? YES or NO

-If so, have you discussed the adoption with them? When?

Describe the marriages/relationships of the adults within the child's household/life, including dates and reasons for separation or divorce.

Describe the current living situation, including number of people in the home, the sleeping arrangements, and the financial status. Have any changes in these areas happened lately?

What are some recent family challenges?

In what areas are the greatest disagreements about the management of the children? Who generally has the final authority?

What are the occupations of each parent and the hours of work per day and week for each of you?

Describe any school challenges your child has had or is having now, (including grades, relationships with teachers, etc.).

- Does your child receive any special education services (i.e. IEP, 504 plan, etc.)

- Has your child ever repeated a grade? _____

What is your perception of your child's self-esteem?

What upsets your child?

Please provide any additional information which you feel may be helpful for this counselor to know.

If there is any information you may feel would be beneficial for this counselor to know, such as diagnostic screening tests, evaluations, psychological reports, IQ achievement tests, personality inventories, written child's history, family trauma, etc, please provide a copy to this counselor. Thank you.

Please check an X on any of the following which apply to your child. If you are unsure but think an item MAY apply, place a question mark (?). Write comments to explain each problem as you perceive it.			
	0	Alcohol use	
	1	Anxious	
	2	Bedwetting	
	3	Competitive, overly	
	4	Crying, excessively	
	5	Daydreams	
	6	Demanding	
	7	Depressed	
	8	Destructive	
	9	Disorganized	
	10	Drug use	
	11	Easily Distracted	
	12	Eating Concerns	
	13	Feels unloved	
	14	Fighting excessively	
	15	Fire setting	
	16	Gang involvement	
	17	Head banging	
	18	Hyperactivity	
	19	Impulsive	
	20	Learning disabilities	

	21	Loner (withdraws/isolates)	
	22	Lying	
	23	Mood swings	
	24	Nail biting	
	25	Nervousness	
	26	Phobia(s)	
	27	Power Struggles	
	28	Rebelliousness	
	29	Running away	
	30	School adjustment	
	31	School truancy	
	32	Self abuse	
	33	Sensitive to criticism	
	34	Sexual Activity	
	35	Sexual orientation	
	36	Shyness	
	37	Sleeping (difficulty/too much/too little)	
	38	Stealing/theft	
	39	Stuttering	
	40	Suicidal threats (or past attempts)	
	41	Temper tantrums	
	42	Verbally aggressive	
	43	Violent behavior	
	44	Other (specify)	

Other Areas of interest:

□ Group Counseling □ Family Counseling □ Anger Management

□ Parenting Education/Parenting Coaching □ Social Skill Building

□ ADD/ADHD Coaching □ Anxiety Management □ Coping Skills □ Stress Management

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Authorization to Release/Exchange Information

Name(s) of Client(s): _____ Date of Birth(s): _____

_____ _____

I, _____, hereby authorize **Stacey Bruen, MC, NCC, LPC**

☑ **to release to:** ☑ **to receive from:**

Name and full address of person/facility:

…the specific information indicated below with regard to the services provided to the above named client(s) for the following purpose(s):

- □ Coordination of treatment with another mental health professional involved in your care.
- □ Coordination of treatment with another type of health professional involved in your care.
- □ To obtain insurance or other third party benefits under a managed care agreement.
- □ For processing of my insurance, employee benefits claim or other financial arrangements.
- □ Coordination with another type of professional (e.g., attorney, custody evaluation, etc.)
- □ Other, specify _____

Such disclosure of written or oral conversations shall be limited to the following specific types of information:

- □ Assessment, diagnosis, treatment plan, compliance, functionality, test results, and response to treatment.
- □ Information pertaining to substance abuse or substance dependency.
- □ Sensitive relationship issues, family dynamics, sexual issues, and other highly personal information.
- □ Other, specify All Available Information

Such The specific use of Protected Health Information (PHI) to be discussed or released are as follows:

- □ Coordination of response to psychotropic medications prescribed by a psychiatrist, physician, or licensed nurse practitioner.
- □ Coordination of other medical treatment with mental health, marital, or family treatment.
- □ Coordination of marital or family treatment with individual treatment.
- □ Case management and/or utilization review under a managed care agreement.
- □ Review of treatment and/or functionality to obtain benefits of non-health-insurance related programs.
- □ Other, _____

I understand that the information to be released includes records in any form, and oral conversations with Stacey Bruen, MC, NCC, LPC. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time unless Stacey Bruen has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Stacey Bruen at the above stated address to be effective.

This authorization shall remain valid until:_____ (6 month duration)

Client/Patient Signature:_____ Date_____