AZ Counseling Perspectives Intake Information
7047 E. Greenway Parkway #250 Scottsdale, AZ 85254

Client Name: _____Today's Date: _____

Address: _____City: _____ State: _____ Zip: _____

Birthdate: _____SSN (optional unless military): _____

Home Phone #. _____Cell #: _____ Work #:_____

May I leave a message? ◉YES ○NO If yes, please indicate: ☐HOME ☐CELL ☐TEXT ☐WORK

Email: _____ May I email you? ◉YES ○NO

Emergency Contact Name: _____ Phone #: _____

Primary Care Dr._____

Medications _____

Insurance Information
If you wish for me to bill your insurance please provide the following information

Insurance Carrier:_____

Insurance Billing Address:_____

Insurance Company Phone # (as shown on insurance card): _____

Name of Primary Insured: _____DOB of Primary Insured: _____

Employer of Insured: _____

ID # (as shown on card): _____ Group #: _____

If Applicable - Authorization #: _____

Client Signature: _____
I authorize the use of my signature on all insurance submissions.
It is **my** responsibility to know what services are covered by my insurance plan. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered

Revised 5/26/23

by my insurance plan. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your current card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient.

Authorization to Bill

It is the policy of this office to keep a credit/debit card on file. You may pay by cash or check if you wish, but a card must still be kept on file

I, _____hereby authorize Bonnie Slater with Counseling Perspectives to bill my Visa/MasterCard/Discover/AMEX:

Credit Card # _____ Exp Date _____

Three Digit (AMEX has four digit code) Security Code # _____Zip Code_____

Name as it appears on the Card _____

I furthermore understand I am fully financially responsible for all patient charges resulting from treatment regardless of whether or not these services/charges are covered by insurance. This includes co-pays and unmet deductibles. I authorize the use of this credit card for any unpaid balances that are 30 days past due. *Please note there is a 1.50 processing fee for credit cards. This fee goes to the payments gateway*

If you do not show up for your scheduled appointment, or you have not notified us that you are canceling your appointment at least 24 hours in advance, you will be required to pay the full cost of the session you scheduled. If Monday is a Holiday, you will need to notify by 3pm the previous Thursday.

_____

Authorized Signature Date

Revised 5/26/23

Informed Consent for Treatment
Client(s) Rights

1. You have the right to ask questions about any procedures used during therapy or about my qualifications as a therapist. If you wish, I will also explain my approach and methods to you. If I see a child under the age of consent, all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the child and therapist.

2. You have the right to decide not to receive therapeutic assistance from me. If you wish, I will provide you with the names of other qualified professionals whose services you might prefer at a cost comparable to my usual customary fee.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision without consulting me, so that your chart may be complete and all fees settled. The cancellation policy will still apply to any appointments scheduled and not attended.

4. You have a right to review your records in the files at any time. I do not keep any "secret notes", so please do not ask me to do so. If you request it, any part of your record in the files can be released to you, or any person or agency you designate. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you

5. One of the most important rights involves **confidentiality**. Within the limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is being seen in therapy, the therapist views the family as a whole as the client. Therefore, releases of information for family sessions require the written permission of every consenting member of the family who was present at any time during the treatment.

6. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) if you threaten grave or bodily harm or death to yourself or another person, I am required by law to notify the appropriate parties or authorities; (b) if a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority; (d) If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; and (e) If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different in what information they require).

7. You have the right to know about the possible harmful results of therapy. In my years of psychotherapeutic service delivery, the only clear harm I have witnessed has resulted from client's use of medical insurance for psychotherapy, Harmful events included: denial of insurability when applying for medical and disability insurance due to DSM-V diagnosis (mental illness diagnosis, which are usually required for reimbursements under medical insurances); company (mis)control of information when claims are processed; loss of confidentiality due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "mental illness", including driver licenses applications, concealed weapons permits, and job applications.

The Therapeutic Process

I, _____ agree to enter into _____therapy and will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of family and personal goals and values; that may lead to a great maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits; however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

I understand that I can leave therapy at any time and that I have no moral, legal, or .financial obligation to complete the maximum number of sessions listed in this contract. I am contracting only to pay for completed therapy sessions. I understand that if my insurance company does not pay for treatment that I will be responsible for payment in full .I understand that the therapist has the right to seek legal recourse to collect any unpaid balance. In pursuing this, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.

Office Policy and Procedure

Fees and Length of Therapy

I agree to enter into therapy with Bonnie Slater of Counseling Perspectives. **I agree to pay $ _____ for each 55 minute session. Payment is due at the start of each session via cash or check or credit card and no balance will be carried forward.**

If you are more than 15 minutes late for a session we will need to reschedule and it will be considered a late cancel.

If using insurance plan to cover costs of treatment, I assign insurance benefits for treatment to Bonnie Slater/Counseling Perspectives to authorize the release of necessary information to my insurance carrier or other agent preparing claims for payment of my office charges. **Co-payment/Deductible of $ ____ is due prior to the start of each session.** I am responsible for cooperating with my insurance company to support prompt payment.

- Other Professional Fees:

1. Expert testimony/depositions: $250.00/hr. to include any times blocked for testimony. Please note this will be collected at the time when the hours are requested to be reserved.
2. Testimony/Deposition preparation 1 hour of preparation per hour of deposition $185.00.
3. Telephone calls/correspondence (except for testimony/deposition) $35.00 (billed in 6 minute increments)
4. Treatment summaries $160.00
5. Records request/letter request $75.00

Insurance Benefits:

My initials indicate that I have read, understand, and agree with each item.

_____It is my responsibility to know what services are covered by my insurance plan. I have reviewed carefully the section in my insurance coverage booklet that describes mental health services. I will call my plan administrator with any questions. I will pay for any services I receive that are not covered by my insurance plan.

_____I will provide full and accurate insurance information at my appointment, or will pay for the appointment on a self-pay basis. It is my responsibility to present my insurance card at the time of my appointment. I will provide updated insurance information promptly in the case of any changes. If I fail to present information, it is not AZ Counseling Perspectives duty to obtain,

_____I understand that I, not my insurance company, am responsible for full payment of my fees. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party.

_____I understand that, if after 90 days, my insurance company has not responded, I will be charged for the balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives.

Missed Appointments and Cancellations:

If you do not show up for your scheduled appointment, or you have not notified us that you are canceling your appointment at least 24 hours in advance, you will be required to pay the full cost of the session you scheduled.

If you would like a reminder card of the next appointment please request.

My initials indicate that I have read and agree with each item

_____I agree that I must give proper notification to avoid late cancellation or no show fees. I agree to call **at least 24 hours** in advance to cancel or change my appointment.

_____For **Monday** appointments, I will call the **previous Friday by 3pm** in order to avoid a late cancellation/no show fees. If Monday is a Holiday, you will need to notify by 3pm the previous Thursday.

I understand that any missed appointment or an appointment cancelled in less than 24 hours (business days) will be automatically billed to my credit card on file.

Signature: _____ Date: _____

Safety Notice

If you EVER think or feel you want to die, hurt yourself, or hurt someone else, and you cannot reach Bonnie at (480) 322-0278, call CRISIS LINE at (866)495-6735 for immediate assistance.