COMPASSIONATE PATHWAYS COUNSELING

Finding Your Way Through

Name:____Date of birth:_______________

Address:____

Preferred Phone:___________________________________Okay to leave message or text? □Yes □No

Email:____

Occupation:____________________________ Employer:_______________________________

□ Single □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Spouse's Name (if applicable)____

Parent's Name (if minor)____

Minor Children and Ages:

_____________________________________ _______________________________________

_____________________________________ _______________________________________

_____________________________________ _______________________________________

Primary Care Physician_____________________ Psychiatrist_________________________________

Current Medications:____

Emergency Contact:_______________________ Phone__________________Relationship___________

Accessibility: If time and attention are needed between sessions, please leave a message for me and I will get back to you within 24 hours. If there is an emergency, you may call me on my cell phone at 623-377-0373. Please be aware that I am often not immediately available as I may be with a client or out of the office. If there is a more severe emergency please call Maricopa County Crisis Line at 602-222-9444 or 911.

Insurance Reimbursement: If your service is covered by insurance you are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance, however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Clients are expected to pay any fees due at the end of each session. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. are not covered by insurance and will be charged at our hourly rate of $100, unless agreed otherwise. At any time during treatment should you become ineligible for insurance coverage you will become responsible for 100% of the fees.

Treatment: I utilize an eclectic approach to therapy. All therapy is individualized focused on your thinking, emotions, behaviors, and relationships. I primarily utilize various methods talk therapy, but may also provide EMDR. Eye Movement Desensitization and Reprocessing (EMDR) is a form of adaptive information processing which may help the brain unblock maladaptive material. EMDR may avoid some of the long and difficult abreacted work often involved in the treatment of anxiety, panic attacks, post-traumatic stress symptoms (such as intrusive thoughts, nightmares, and flashbacks), dissociative disorders, depression, phobias, identity crisis and other traumatic experiences. If this treatment is accepted you acknowledge: 1) Distressing unresolved memories may be surfaced through the use of EMDR procedure 2) Some patients or clients experience reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including but not limited to, high level of emotional or physical sensation. Subsequent to the treatment session, the processing of incidents and/or material may continue and dreams, memories, flashbacks, feelings, etc., may surface 3) Those with limiting or special medical conditions (pregnancy, heart condition, ocular difficulties, etc.) should consult their medical professionals before participating in this therapeutic method 4) For some people, this method may result in sharper memory, for others fuzzier memory following the treatment. You acknowledge that before commencing EMDR treatment that you have considered all of the above and have obtained whatever input and/or professional advice you deem necessary or appropriate. You acknowledge that your consent if free from pressure, and you agree to hold harmless your EMDR clinician and Compassionate Pathways Counseling for any unpleasant or unexpected effect which may arise from your experience. You understand that you may stop treatment at any time before or during any EMDR session and that more than one EMDR session is necessary in the treatment

Fees: The fee is $100 for 50 minute counseling sessions. Unless other arrangements are made, fees will be remitted at the end of each session. Checks should be made out to Compassionate Pathways Counseling. Should I be subpoenaed to serve as a witness of fact, I will charge $360/hour, includes travel time, plus expenses.

Confidentiality: All work done within the therapeutic relationship is confidential. Who you are, what you say, and what you do will be held in confidence and respect with the following exceptions:

- Intent to harm self or others. If you intend to harm a reasonably identifiable victim or yourself, confidentiality may be broken to ensure the safety of yourself and others.
- Child abuse: If there is a report of any ongoing physical, sexual, or emotional abuse or neglect for a child, a report will be made to Arizona Department of Child Safety.
- Dependent/Elder Abuse: If there is a report of abuse of an elder or otherwise incapacitated adult, a report will be made to Adult Protective Services.
- Collections: If payment is not made for three months or more, and no other arrangements are made, your name may be given to a collections agency to attempt remittance.
- A signed letter of release of confidentiality.
- Subpoena: A court of law may subpoena records
- In order to facilitate my continued professional growth and get you the benefit of a variety of professional experts, I may discuss our work together with another therapist or trusted colleague. If this occurs, your identity will be disguised.

Cancellation: Please give at least 24 business hours notice when canceling an appointment. Failure to do so will result in a $40 charge, however exceptions may be made in cases of sudden illness or emergency. **Missed appointments are not covered by your insurance.**

Initial_______

Termination: You have the right to terminate treatment at any time, without retaliation. I recommend that there be at least one session prior to termination for closure. I may terminate therapy with you if payment is not made, if progress has not been made in therapy, if it is not in your best interest to continue treatment, or if there is a refusal to follow therapeutic recommendations (such as remaining sober or refilling prescriptions, etc). At this time, you would be given recommendations for continued care. If you are out of contact with your therapist for 30 days, your case will be considered closed.

Records

All client records are kept for six years. Records are stored electronically, on a HIPAA compliant site. All efforts are mad to protect your information. You must notify me if you choose to opt out of electronic record keeping. You are entitled to receive a copy of your records, or I can prepare a summary for you with your written consent. Requests must be sent to Mandy Schulzke, LPC. Because they are professional records, they can be misinterpreted by untrained readers. Therefore, it is highly suggested that initially we review them together or they be sent to another mental health professional so that you can discuss them with that professional.

Consent for Treatment

I, the undersigned, authorize and request my practitioner to carry out psychological treatment and/or diagnostic procedures, which now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and emotionally painful reactions. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. I attest that I have received and read the HIPAA Notice of Privacy Practices (provided separately). The HIPAA Notice of Privacy Practices is incorporated by reference into this document.

____ ____________________

Signature Date

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent. If not signed by both parents of the minor, please be aware that the parent who does not sign has the right to terminate treatment unless you have sole custody or a court order directing counseling to happen.

____ ____________________

Signature of Parent or Guardian Date

____ ____________________

Signature of Parent or Guardian Date