Welcome to my counseling practice. Since you are receiving this introduction letter, you have likely scheduled your first appointment with me. The first session is usually focused on the clinical assessment process and is unlike "counseling" in that it is very structured with the counselor asking a multitude of questions in an attempt to get an overview of the issues that have brought you to counseling. After your first session, I will be able to give you some initial feedback and a tentative plan on how we can move toward your goals for our time together.

Since many people I see have never been in counseling before, I find it useful to put some of my policies in this introductory letter for your information. Even if you have been in counseling before it would be useful to review these policies because some of them might have changed or be unique to my practice.

Appointments. Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve an hour or more 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, Monday through Friday) prior to your appointment if you need to cancel. Appointments for Monday must be canceled by the prior Friday at 5:00 P.M. ***You will be billed for appointments you fail to cancel in accordance with this policy. In addition, if you arrive late to an appointment, the end time will remain as scheduled and you will be charged for the full appointment hour I have reserved for you.***

Length of Sessions. There are sometimes misunderstandings about the length of sessions. Therapy sessions, as defined by the American Medical Association Current Procedural Terminology coding, are 45-50 minutes, 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 45-50 minutes.

Confidentiality. Subject to the provisions outlined in the Informed Consent and HIPAA Privacy documents in this New Client Packet, I will do the utmost to maintain your confidentiality. This includes the fact that you *are* a client. If we encounter each other in the community, I may nod or smile, but I will not acknowledge you as anyone I know. I'm not trying to be rude, but attempting to maintain your confidentiality.

Phone Contact. I have a strong preference for face-to-face contact when I do 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. In those situations, you need to be aware that insurance companies and managed care organizations generally do not reimburse for these services. Telephone counseling should be scheduled for a mutually-agreeable time and will be billed at $30 for each 15 minute period of counseling during normal business hours. Evenings, nights and weekends are billed at an additional premium.

Michael Rehm, MA, LPC, License #LPC-14136
mikerehm@stillwatersaz.com

Informed Consent for Assessment and Treatment
Michael Rehm, MA, LPC, CCTP

Therapy offers a unique relationship between the client and therapist. This document has been developed in order to ensure that there are no misunderstandings about the various aspects of counseling services provided at NPCC. Although this document is long and perhaps complex, it is important that you read it carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between you and Stillwaters Counseling, LLC. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it.

Education and Services

I completed my undergraduate studies at Arizona State University and earned a Master of Arts in Professional Counseling from Ottawa University. I also have a Graduate Diploma in Christian Counseling from Phoenix Seminary. My experience includes work in trauma, abuse, and deprivation. I am licensed by the Arizona Board of Behavioral Health Examiners as a Licensed Professional Counselor.

My world view is grounded in biblical spirituality. It is not essential that you share my beliefs, but you have the right to know that my value assumptions are rooted in my Christian faith. I offer integrative therapy to adults, individuals and/or couples, and families. The primary focus of my practice is adults; minors are only occasionally seen in some form of family therapy where at least one adult also participates in the treatment. I specialize in the treatment of trauma, abuse, and deprivation, including sexual abuse, relationships, and adjustment. Clients that present in counseling with eating disorders, violent behaviors, or certain personality disorders as their primary problem will be referred to other professionals or programs that specialize in these areas. I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experiences.

Confidentiality Statement

Your emotional, physical, and spiritual wellbeing are of utmost importance to me. I am committed to your care and to the confidentiality of all personal information shared in our therapy sessions, except in circumstances governed by law. State and federal laws define the limitations of confidentiality as when there is a real or potential danger to you or others, when the courts issues a subpoena, or when child/elder abuse or neglect is involved. There are other possible circumstances when information may be released, including disclosure required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against me, to comply with the United States Patriot Act, and to comply with other federal, state, or local laws. In addition, your case may be discussed with other professionals for consulting purposes. On those occasions, your name will be withheld from our discussions. The rules and laws regarding confidentiality, privacy, and records are complex. The HIPAA NOTICE OF PRIVACY PRACTICES included with this document details the considerations regarding confidentiality, privacy and your records. Periodically, the HIPAA NOTICE OF PRIVACY PRACTICES may be revised. Any changes to these privacy practices will be provided. **It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.**

_____ Initials **I have read the HIPAA NOTICE OF PRIVACY PRACTICES and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the HIPAA NOTICE OF PRIVACY PRACTICES may be revised.**

If you would like me to speak with another healthcare provider or obtain records from previous treatment, you will need to sign a "Release of Information" form. If one of the unusual circumstances previously stated does arise when I am forced to release information about you, I will personally contact you and will do everything in my power to release minimal information.

It is important to be aware that I use a number of electronic tools in my practice, including computers and the internet, email, PDA, fax machines, telephone, and cell phone. I may use these tools to store or communicate

information about you and your treatment. While reasonable backup, security, and other safeguards are in place, there is always some risk of inadvertent disclosure of information that comes with using these tools. By signing this informed consent, you agree to accept the risk of disclosure that comes with tools that I use in my practice.

During times when I am out of town or otherwise unavailable, I reserve the option to 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.

Financial Agreement

Payment is expected at the time the service is rendered unless other arrangements have been made. 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. All payments are made to Stillwaters Counseling. I do not participate in managed care insurance plans, but will provide you with a superbill that you can submit to your insurance company for possible reimbursement. ***You are responsible for the full fee regardless of your insurance company's reimbursement policy.*** I reserve the right to change my fees with 30 days' notice, and to use the services of a third-party collections service, when necessary. Refunds are not made after the services have been rendered. My current fees are as noted on the Payment Agreement form.

No-Show and Cancellation Policy

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. Appointments canceled at the last minute are very detrimental to my practice, therefore, a 24 hours' notice is required for cancellations or you will be charged a cancellation fee. ***A no show/no call will be charged full fee.*** A cancellation within 24 hours will be charged 75% of the reserved-time fee. Repeated late cancellations or missed appointments may result in termination of therapy. ***In addition, if you arrive late to an appointment, the end time will remain as scheduled and you will be charged for the full appointment hour I have reserved for you.***

Emergencies

My practice does not have the capability to respond immediately to counseling emergencies. In the event of a life-threatening emergency, please call 911 or go to your local Emergency Room. You may also utilize community crisis hotlines (Empact 480-784-1500; Banner Help Line 602-254-4357). Established clients with an urgent need to make contact with me may call the cell phone number provided at your first session, but an immediate response is not guaranteed.

Purpose and Limitations of Therapy

Counseling has been shown to have many benefits, including better relationships, solutions to specific issues, and significant reduction in feelings of distress. However, there are no guarantees of what you will experience. The process of therapy involves working through tough personal issues that may result in uncomfortable emotions such as anger, fear, or frustration. Attempting to resolve these issues may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use, education, relationships, or any other area of your life.

Sometimes, a decision that is personal growth for one family member is viewed negatively by another family member. Change can be easy, but usually it is slow and frustrating. In family counseling, interpersonal conflict may increase as we discuss family problems and issues.

In most cases, one or more mental health diagnoses will be rendered during the process of assessment and treatment. Some diagnoses may affect employment in high security or safety sensitive positions or affect your ability to obtain future insurance. You have the right to refuse any recommended treatment or to withdraw consent to therapy and to be advised of the possible consequences of withdrawal or refusal. I welcome your input and questions about our course of treatment. *Your satisfaction in therapy is very important to me!*

Our relationship is very unique and it is exclusively a therapeutic, professional relationship. Thus, it is inappropriate

for a client and therapist to have a social relationship. Bestowing gifts and attending family or religious functions would be a violation of the boundaries of our therapeutic relationship that serves to protect your confidentiality.

If you ever feel you have been treated unfairly or disrespectfully, please talk with me about it. This is never my intention, but at times misunderstandings can result in hurt feelings. Addressing these issues right away is important so that your progress in therapy is not hindered.

Litigation Considerations

If you become involved in the legal system (divorce, custody, civil litigation, criminal activity, etc.) you can expect that I will not make recommendations, testify, or get otherwise involved in your legal activities. It is an inherent conflict of interest for a treating professional to also offer evaluations or opinions in legal matters. If a client has these expectations, it can affect their willingness to disclose personal information vital to treatment. If you need an evaluation for legal reasons, I will make a referral to an outside, unbiased professional who can perform this service. ***In signing this agreement, you agree that you will not call me as a witness to testify or to expect recommendations or other involvement in your legal activities.***

STATEMENT OF UNDERSTANDING

I have read and understand this information and am giving my informed consent to treatment. In the case of a minor child, I affirm that I am the custodial parent or legal guardian of the child, and I authorize services for the child under this agreement.

Name:_____ Phone:_____

Address:_____ Leave Voicemail Acceptable: □ Yes □ No

City:_____ State:_____ Zip: _____ Date of Birth: _____

Signature:_____ Date: _____

In the case of minor children, please specify the following:

Full Name of Minor:_____ DOB:_____ Relationship:_____

Full Name of Minor:_____ DOB:_____ Relationship: _____

For office use only - verification that client has read and understands informed consent document

Authorized Representative:_____ Date: _____

Client Information

Name:_____ Date: _____

Address: _____ _____ _____ _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Check if okay to leave a message at: Home ____ Work ____ Cell ____ Email ____ Other _____

Employer: _____ Occupation: _____

Date of Birth: _____ Male _____ Female _____

Level of education: HS ____ College ____ Graduate Degree ____ Other: _____

Marital Status: _____ Years married: Present marriage _____ Previous marriage(s) _____

Name of Spouse: _____ Date of Birth: _____

Children's Names	Sex	Age

Emergency Contact Person: _____

Phone: _____ Relationship: _____

If client is a minor, client resides with: Mother ____ Father ____ Both ____ Other ____

Referred by (optional): _____ May we thank them for referral? Yes ____ No ____

If referred by a doctor, may we have permission to contact that doctor? Yes ____ No ____

Name: _____

Address: _____ Phone: _____

What hobbies, if any, do you have? _____

What do you do for recreation, physical activity? _____

Do you smoke? Yes ____ No ____ If yes, how much/day? _____

How would you rate your current physical health? Excellent ____ Good ____ Fair ____ Poor ____

Are you currently experiencing any physical problems? Yes ____ No ____ If yes, please explain: _____

_____

Date of last physical examination: ____ ____ ____

Previous hospitalizations:

Date: ____ Reason: _____ Date: ____ Reason: _____

Have you ever been an inpatient for mental health reasons? Yes ____ No ____ Approx. dates: _____

Are you currently suicidal? Yes ___ No_ Suicidal thoughts only? Yes__No____Previous suicide attempts? Yes_No _

Any aggressive/violent thoughts or acts? Yes_No Any past aggressive/violent thoughts or acts? Yes_No _

Family Physician's Name: _____ Phone: _____

If you are taking any medications, please list:

Medication(s) – Prescription and Over the Counter	Dosage	Prescribed For

Please check all that apply:

Current	Past		Current	Past	
_____	_____	Depressed mood	_____	_____	Recurrent & persistent thoughts/behaviors
_____	_____	Daily irritability	_____	_____	Difficulty controlling anger/bad temper
_____	_____	No interest/pleasure in activities	_____	_____	Psychological abuse (emotional/verbal)
_____	_____	Increase/decrease of appetite	_____	_____	Physical abuse
_____	_____	Difficulty sleeping/poor sleep	_____	_____	Sexual abuse
_____	_____	Increase/decrease need for sleep	_____	_____	Distressing memories that reoccur
_____	_____	Difficulty concentrating	_____	_____	Recurrent distressing dreams
_____	_____	Difficulty making decisions	_____	_____	Delusions (unreasonable thoughts/beliefs)
_____	_____	Fatigue or loss of energy	_____	_____	Do you hear or see things others don't?
_____	_____	Feelings of worthlessness	_____	_____	Not able to control impulse to steal
_____	_____	Feelings of hopelessness	_____	_____	Preoccupation with/or frequent gambling
_____	_____	Recurrent thoughts of death	_____	_____	Sense of reliving traumatic events
_____	_____	Racing thoughts or ideas	_____	_____	Periods of time you cannot remember
_____	_____	Rapid mood swings	_____	_____	Intense reactions to certain events/anniversaries
_____	_____	Shortness of breath/dizziness	_____	_____	Avoidance of thoughts or feelings of trauma
_____	_____	Sweating/feeling flushed	_____	_____	Avoidance of activities or situations of trauma
_____	_____	Choking	_____	_____	Detachment from feelings, people, places
_____	_____	Nausea or abdominal distress	_____	_____	Binging/compulsive overeating
_____	_____	Feeling unreal	_____	_____	Intentional vomiting
_____	_____	Numbness or tingling sensations	_____	_____	Laxative or diuretic use
_____	_____	Fear of dying	_____	_____	Excessive dieting
_____	_____	Sexual orientation issues	_____	_____	Compulsive exercising
_____	_____	Accelerated heart rate or chest pains	_____	_____	Compulsive sexual behaviors
			_____	_____	Fear of going crazy

Substances Used/Abused

Current	Past		Current	Past		Current	Past		Current	Past	
_____	_____	Alcohol	_____	_____	Prescription (Rx)	_____	_____	Ecstasy	_____	_____	Barbiturates
_____	_____	Cocaine	_____	_____	OTC Medication		_____	Opiates	_____	_____	Hallucinogens
_____	_____	Marijuana	_____	_____	Narcotics		_____	Amphetamine	_____	_____	Other (identify)

Briefly, what difficulties or problems have brought you to seek help at this time? _____

_____

_____

When did these problem(s) begin? _____

On a scale of 1-10, rate your current level of distress: **1** (Mild) **2 3 4 5 6 7 8 9 10** (Severe)

Have you been to counseling before? Yes____No _____

If yes, from_____to_____, with whom and what was the nature of the counseling?

_____

_____

Have you consulted with a minister or pastor? Yes_____ No____ If yes, from_____to_____, with whom and what was the nature of the consultation?

_____

Do you attend a church or other place of worship?_____ How often do you attend? _____

Where? _____

Describe briefly your view of your relationship with God: _____

_____

_____

Date **Signature**

PRIVACY NOTICE
Revision Date: 4-21-16

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET A COPY OF THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is to help you to understand private health information (PHI), how it may be used or shared , and what your rights are to permit, review, obtain, amend, restrict, or revoke release of your PHI. We are required by law (Health Insurance Portability and Accountability Act - HIPAA Privacy Rule) to give you this notice. This notice will describe for you examples of how your information may be used or shared.
PHI includes identifying information (name, date of birth, social security number, address, diagnosis, lab results, medications prescribed, services billed, paid for, or denied) that we have received from you directly, which was created in the course of your care with Stillwaters Counseling (SWC), received from other health care providers, or provided by your healthcare insurance provider. The Health Insurance Portability and Accountability Act (HIPAA Privacy Rule) permits SWC to exchange your PHI for treatment, payment, and behavioral healthcare operations.
By law SWC is required to:

- Keep your PHI information protected and private;
- Provide you with a notice of SWC duties and policies concerning your personal data;
- Comply with federal, state, and SWC policies protecting your personal data;
- Notify you of any unauthorized acquisition, access, use or disclosure of PHI not permitted under HIPAA Privacy Rule unless there is a low probability the PHI has been compromised based on a risk assessment.

SWC <u>does not need</u> your permission to release your PHI:

- to receive payment for your treatment;
- to conduct organizational operations including the review of client care and areas to improve;
- to provide, coordinate, or manage your behavioral health care and any related services within SWC, or with an entity with whom SWC has a properly executed Business Agreement, and includes sharing information with a third party that has already obtained your permission to have access to your PHI;
- to use and share your information in an emergency treatment situation;
- to comply as required by federal, state or local law;
- to lessen or prevent a serious threat to health or safety;
- to comply with Public Health Activities, SWC may share information about you as necessary in the report of death, abuse, neglect, or domestic violence as required by law, or report to public health authorities to control or prevent disease, injury, or disability;
- to comply with civil rights laws;
- to comply with law enforcement officials for specific purposes such as by a court order or similar legal process requires us to do so, protective services for Government Officials, National Security and Intelligence Activities;

SWC <u>does need</u> your written permission:
SWC will seek your written permission for the following types of PHI disclosures:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes;
- Disclosures that constitute a sale of protected health information;
- Other uses and disclosures not described in this Notice.

Uses of information which need your written permission, called an **authorization**, are described above. You have the right to change or deny your written authorization at any time. To **revoke** (deny) your authorization, contact your SWC care professional to discuss your situation and how it will affect your treatment. Please be advised that we are unable to retrieve any information SWC was previously authorized by you to release.

Your Rights Regarding Your Health Information:

- You have the right to ask to inspect or request your health information that has been created in electronic, digital, or paper form. Under some circumstances we may deny your request to inspect or copy your information. To exercise this right please request and complete the *Client Request to Copy/Read Private Health Information Form*. Return to Stillwaters Counseling, 4500 North 32nd St, Suite 106, Phoenix, AZ 85018.
- You have the right **to amend or change** any health information used to make decisions about your care. To request a change of your health information, please request and complete a *Client Request to Amend Private Health Information Form* and return to the Stillwaters Counseling, 4500 N 32nd St, Suite 106, Phoenix, AZ 85018. Be advised, we may deny your request for amendment if you ask us to amend information that:
    - Was not created by SWC;
    - Was created by someone no longer available to make the amendment;
    - Is not part of the information which you would be permitted to inspect or copy, or;
    - Is accurate and incomplete.

- You have the right **to request information release restrictions**. To request a restriction, you must request and complete a *Request for Restriction form* and send it to the SWC Privacy Officer at SWC , 4500 N. 32nd St., Suite 106, Phoenix, AZ 85018 and state how and to whom you want the information restricted. You may request that SWC restricts uses or disclosures of PHI about your care for treatment, payment, or health care operations, but the HIPAA Privacy rule states that SWC is not required to agree to a restriction, except when you do not want your health care insurance provider to be notified, and you have paid in full with your own resources for services you received. We are not required to agree to a restriction that is needed to provide you with emergency care. We may also deny a restriction if it is not in writing or does not include a reason to support the request.
    - You have the right to request an **Accounting of Disclosures.** To request this list or accounting of disclosures, you must contact your SWC professional to obtain a *Request for Accounting of PHI Disclosed by SWC form*. Review and complete the form with the SWC staff person and return it to the SWC Privacy Officer, Stillwaters Counseling, 4500 N 32nd St, Suite 106, Phoenix, AZ 85018. Be advised that we cannot account for any time periods that are beyond six years from the date of request. Note that by law we are not required to account for disclosures regarding treatment, payment, or healthcare operations, or information, which you have given SWC written authorization to release.
    - You have the right to request that SWC contact you in a confidential manner in regards your care such as appointment reminders, or mail notifications.
    - You have the right to receive a paper copy of this Privacy Notice at any time. To receive a copy, please contact our Privacy Officer at 602-762-1463.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with SWC or with the Secretary of the Department of Health and Human Services. To file a complaint with SWC, please contact the Privacy Officer in writing at Stillwaters Counseling, 4500 N 32nd St, Suite 106, Phoenix, AZ 85018. All complaints must be sent in writing to the Privacy Officer. You will never be punished or penalized for filing a complaint.

WE MAY CHANGE THIS NOTICE

We have the right to make changes in this notice effective for health information we already have about you as well as any information we may receive in the future. We will post a copy of the current notice in all of our SWC facilities. The notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you register at or are admitted to SWC for treatment we will offer you a copy of the current notice in effect. If you have a question about this notice, please call the Privacy Officer at 602-762-1463.