21620 N 19th Ave, Suite A-102

Phoenix, AZ 85027

602 751 5584

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number where we may call you? Okay to leave message? \_ \_

Emergency contact & phone:

Education (years completed or highest degree): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_ Never Married \_\_ Divorced \_\_ Widowed \_\_ Married/Partnered: \_\_\_\_\_\_\_\_\_\_

Spouse/Partners Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Partners Occupation/Employer:

Primary Health Insurance: Policy Holder's Name:

Health Plan ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID #:

Policy Holder's Address:

Policy Holder's DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer:

Relationship to patient:

**INFORMED CONSENT**

I, the undersigned, voluntarily consent to participate in psychotherapeutic services provided by Mosaic Counseling. I understand that I may withdraw from therapy services at any time. I certify that I am the legal guardian or custodial parent with the legal right to request and approve evaluation and treatment of my minor child and herby consent to their treatment. I understand that I have the right to have any complaints heard and resolved in a timely manner.

Client Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Other Participants: Date:

**FINANCIAL POLICY**

Mosaic Counseling accepts clients with insurance coverage as well as private pay clients. It is important that you understand that your insurance coverage is a contract between you and the insurance carrier. Mosaic Counseling will file your insurance claims and wait a reasonable amount of time for your insurance company to pay the claim. If a claim remains unpaid by your insurance company for more than 90 days, we will look to you for payment of the claim. It is highly recommended that you become very familiar with your insurance policy and what your benefits are under your policy. It may be necessary for you to call your insurance carrier directly to gain some clarification regarding your benefits. In most cases, you will have a co-pay or a deductible which will be paid to our office prior to your appointments. Billed balances are due and payable within 30 days. Mosaic Counseling does have the right to share your billing information to a collection agency if you have a balance that has been left unpaid more than 90 days. Payment plans for unpaid balances may be an option and would need to be discussed.

**Mosaic Counseling has a cancellation policy which requires you to cancel your session within 24 hours prior to the session to avoid being charged. The charge for late cancellations and appointments in which there is no cancellation and no attendance is $30.00.** We understand that at times there may be extenuating circumstances which prevent you from canceling or coming to your appointment and these situations will be considered on a case-by-case basis.

Below are the rates for **private pay** clients and for **services that are not covered by insurance**:

Intake/Assessment (1hour) $150.00

Individual, Couples, Family Therapy Session (45 – 50 minutes) $125.00

Individual, Couples, Family Therapy Session (60 minutes) $150.00

Open Path Collective Fee (45 – 50-minute session) $50.00

Court-Ordered Services (Therapeutic Intervention, Safe-Haven Counseling) $150.00 per hour

DOT/SAP Evaluations (90 – 120 minutes, plus follow-up appointment and all paperwork) $350.00

Paperwork completed during a session – no charge

Paperwork outside of a regular session – $20 per 15 minutes

Late Cancellation/No shows $30.00

Sliding Scale on a case-by-case basis – $90.00 - $125.00 (60 minutes)

Court Appearances (includes travel and wait time) $300.00 per hour

Disability related forms are provided after a minimum of three sessions and there will be a charge if not completed during a therapy session.

Return Check Fee $25.00

ALL PAYMENTS (INCLUDING COPAYS AND DEDUCTIBLES) ARE DUE AT THE TIME OF SERVICE.

I authorize my insurance company to pay Mosaic Counseling directly for services rendered for myself, my children, or my spouse.

I have read and understand this policy and will honor the guidelines of this policy

Signature/Date

**TREATMENT/CONFIDENTIALITY AGREEMENT**

The law protects the confidentiality of communication between clients and mental health professionals. Information can normally only be released about you to others with your written permission, though there are some exceptions you should be aware of

* When there is a suspected abuse of a child or vulnerable adult.
* When it is your therapist’s professional opinion that you are in danger of harming yourself, another person, or are unable to care for yourself.
* If you report to your therapist that you have intentions of physically harming someone, your therapist is required to inform that person of your intentions and notify the proper authorities.
* When the information is required by your insurance carrier for Mosaic Counseling to be reimbursed for services provided or for quality management services.
* Your therapist may disclose your information to another licensed therapist for supervision, consultation, or to coordinate services.

Appropriate assessment and treatment records are required to be kept by law and professional standards. Due to these being professional records it is possible for them to be misinterpreted by someone who is not familiar with mental health records. You do have the right to view your records, however it is not our practice for clients to review them directly without professional interpretation.

**Emergency/After-Hours Calls:** If you need to call after hours, you may reach the confidential voice mail system. You will be prompted to call 9-1-1 if the call is urgent. You may also text or email and, if not urgent, your message will be returned during regular business hours. Office hours are Monday – Friday, 9:00am – 4:00pm. If you are unable to reach your clinician and feel that you can’t wait for a return call, contact your family physician, the nearest emergency room, the Maricopa Crisis Team at 602 222 9444, or call 9-1-1.

**Coordination of Care:** **I authorize Mosaic Counseling to contact my PCP** (circle one) **yes no**

PCP name, address, phone:

**Benefits and Risks:** Psychotherapy has both benefits and risks. Self-exploration, gaining insight, exploring options for dealing with problems, learning new skills, or venting difficult feelings/experiences are generally quite useful, but some risks do exist. As counseling begins, please understand that some people experience uncomfortable feelings and that examining issues may trigger feelings of unhappiness, anger, guilt, grief or frustration. These feelings are a difficult, but natural part of the psychotherapeutic process and often provide the basis for change. Important personal decisions are often an outcome of counseling and are likely to produce new opportunities and as well as unique challenges. If at any time you are uncomfortable with a suggestion or comment that has been made, please discuss this with your counselor. Psychotherapy requires a very active effort on your part. To be most successful, you should work on things we discuss outside of sessions.

**I have read and agree to the above terms:**

Client Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Reason for visit** (circle all that apply) Do you feel/have any of the following:

Feel sad/depressed, manic highs, anxiety/panic, lifelong problems with focus/attention/concentration, lifelong problems with being hyper/impulsive, fears, obsessive thoughts, compulsive rituals, posttraumatic stress, anger, paranoia/suspicions, hallucinations, problems with alcohol, problems with drugs, change of insurance, psychiatric second opinion, recent geographical move to the Phoenix area, job-related problem or other (describe)

Was there an event which made these issues or problems surface? Y N

If yes, please describe:

**LIST/DESCRIBE WHAT CHANGES YOU WANT TO MAKE WHILE IN COUNSELING:**

**PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:**

No Little Some Much Significant Not

Effect Effect Effect Effect Effect Applicable

-------------------------------------------------------------------

Marriage/relationship 1 2 3 4 5 N/A

Family 1 2 3 4 5 N/A

Job/School Performance 1 2 3 4 5 N/A

Friendships 1 2 3 4 5 N/A

Hobbies 1 2 3 4 5 N/A

Financial Situation 1 2 3 4 5 N/A

Physical Health 1 2 3 4 5 N/A

Anxiety Level/Nerves 1 2 3 4 5 N/A

Mood 1 2 3 4 5 N/A

Sexual Functioning 1 2 3 4 5 N/A

Ability to Concentrate 1 2 3 4 5 N/A

Ability to Control Temper 1 2 3 4 5 N/A

Spirituality 1 2 3 4 5 N/A

Eating Habits 1 2 3 4 5 N/A

Sleeping Habits 1 2 3 4 5 N/A

**WEIGHT**:  Unchanged  Weight gained (Last 6 months)  Wt. Loss (6 months)

 Purging (Freq) /  Binging (Freq) /  Laxative Use  Diuretic use  Diet Pills

**SLEEP:**  Unchanged  Can't fall asleep  Sleep constantly  Awaken early  Nightmares

 Can't wake up  I sleep but I don't feel rested

**TREATMENT HISTORY:**

Have you ever seen a counselor or psychiatrist for any reason? (If yes, please list when and why)

Number of previous counselors: Number of previous psychiatrists:

Have you ever been hospitalized for a psychiatric reason? (If yes, please list when, where, and why)

Have you ever received treatment for drugs or alcohol? (If yes, please list when and where)

Have you ever attended any self-help groups such as AA/NA, CODA, etc.?

**SUICIDAL/HOMICIDAL THOUGHTS:**  Yes, current  Yes, in the past  No

**SUICIDAL/HOMICIDAL PLAN OR INTENT:**  Yes, current  Yes, In the past  No

If you feel like hurting yourself now, do you have a plan? (If so, please explain)

Past attempts: No  Yes Number of attempts  Self- mutilation

Date of last attempt: Method:

Have you ever been violent or hurt someone? If yes, please explain:

**MEDICAL HISTORY**

Are you currently under the care of a physician? Yes No Reason?

Major Medical Problems and dates: (accidents, surgeries, etc.):

Please list any prescription or over the counter medications you are currently taking:

Drug Allergies? If yes, please list

Females: # of pregnancies # of live births # of miscarriages # of abortions

History of postpartum depression?

Concussions/Head Trauma/Seizures (give specifics):

**Family Information**

Family members living with you: Please list Name, Age, Relationship to you

1

2

3

4

5

6

Number of previous marriages:

**Family History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | (circle all that apply): |  |  |  |
| Mother | Mental Health | Drugs | Alcohol | Major Medical |
| Father | Mental Health | Drugs | Alcohol | Major Medical |
| Sisters | Mental Health | Drugs | Alcohol | Major Medical |
| Brothers | Mental Health | Drugs | Alcohol | Major Medical |
| Maternal Grandmother | Mental Health | Drugs | Alcohol | Major Medical |
| Maternal Grandfather | Mental Health | Drugs | Alcohol | Major Medical |
| Paternal Grandmother | Mental Health | Drugs | Alcohol | Major Medical |
| Paternal Grandfather | Mental Health | Drugs | Alcohol | Major Medical |

**Social History**

I was born in and raised in by

My parents are (circle one) married, divorced, separated, deceased.

I have (number and age) brothers sisters.

My relationship with my mother was/is with my father was/is

My childhood was (circle one) happy, unhappy, abusive

History of being the victim of abuse (circle all that apply): none, verbal, emotional, physical, sexual, rape

Military Service: Branch Dates of service Type of discharge

Please list your support network/systems:

Legal/financial issues:

**SUBSTANCE/ALCOHOL USE**

Do you or have you ever had a substance abuse problem?  No  Yes  Now  In the past

Have other people thought you might have a substance abuse problem?  No  Yes  Not currently

Drugs used (indicate past or present, include alcohol):

Drug of choice: Date of last use

Method/:  IV  Snorted  Swallowed  Smoked

Frequency/Amount:

Do you believe someone in your family might have a substance abuse problem?  No  Yes Who?

Do you use tobacco?  No  Yes If so, how much daily?

**ALCOHOL RELATED EXPERIENCES IN THE LAST SIX MONTHS**

 Binges  Job problems  Sleep disturbance  Physical withdrawal

 Hangovers  Arrests  Blackouts  Passed out

 Assaults  Medical complications  Seizures  Concern over driving

 Interpersonal problem  Inability to stop after the 1st drink

 DUI – If yes, dates:

Other Substance use (in the last six months) Substance: Freq. Amount Duration:

Is there anything else you think we should know to be helpful?

Client Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Participant(s) Signature/Date: