



Creating Balance, LLC
Shanna Larson-Paola, President
Licensed Marriage and Family Therapist
8115 E. Indian Bend Road, Suite 119,
Scottsdale, AZ 85250
480.447.3332

Please fill out the following and bring this intake form to your first appointment.

Personal Information Form

Name: _____ Date: _____

Address: _____

Phone : _____ Email: _____

Age: _____ Date of Birth: _____ Occupation: _____

Place of Employment: _____

Marital Status:

- Married Single Cohabitation Divorced Dating Engaged Widowed
- Remarried Separated

Years Married: _____ Age Married: _____ Previously Married (If so, how long?): _____

Spouse's Name: _____ Spouse's age: _____ Date of birth: _____

Occupation: _____ Place of Employment: _____

Names, ages, and birth dates of children: _____

What are your goals for coming to therapy? _____

How did you hear about me? (referral source): _____

Have you ever seen a professional counselor before? _____

Why were you seeking help? _____

Was counseling beneficial? _____

Who was your counselor? _____

Medical and Health Information

Family Physician(s): _____

Current Medical Problems: _____

Are you now or have you ever had suicidal thoughts? _____

Do you have troubling thoughts that you cannot seem to get rid of? Any problems related to thinking, concentrating, or memory? _____

Medications: _____

Past Physical Problems: _____

Have you ever been prescribed sedatives to help you sleep? YES NO

Have you ever been prescribed medication to help with depression? YES NO

Do you drink alcohol on a regular basis? YES NO

Do you smoke? YES NO

Have you ever taken/ used any illegal drugs? YES NO

If yes, please indicate: _____

Emergency contact information:

Name: _____ Relationship: _____

Phone: _____ Email: _____

Client Signature: _____

Informed Consent--Acknowledgement and Understanding

PROFESSIONAL INFORMATION

Creating Balance, LLC
Shanna Larson-Paola, President
Licensed Marriage and Family Therapist
Master's Degree, 2000
Bachelor's Degree, 1997
Focus: Individual, Couples and Family Therapy

PSYCHOTHERAPIST--- CLIENT SERVICES AGREEMENT (HIPAA)

This document contains important information about the professional services and business practices of Creating Balance, LLC (CB, LLC). It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a federal law that provides privacy protection and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that CB LLC provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is part of this Agreement, explains HIPAA and its application to your personal health information. The law requires that CB LLC obtain your signature acknowledging that CB LLC has provided you with this information. Although these documents are long and complex, it is important that you read them carefully. We can discuss any questions you have. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will bind CB LLC unless we have taken action in reliance on it; if there are obligations imposed on CB LLC by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy (Therapy) is not easily described in general statements. It varies depending on the personalities of the therapist and client and the particular problems you are experiencing. There are many different methods which may be used to deal with the problems you hope to address. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during and outside of our sessions.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits that can lead to better relationships, solutions to specific problems and significant reductions in feelings of distress. **However, there are no guarantees of what you will experience.**

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me as your therapist. Therapy involves a large commitment of time, money and energy so you should be diligent about the therapist you select. If you have questions about my procedures please discuss them whenever they arise. If

your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS/SCHEDULING

An evaluation will last from 2 to 4 sessions. During this time, we will decide if I am the best person to provide the services you need to meet your treatment goals. I define a “therapy hour” (session) as a 50 minute appointment that includes therapy, scheduling and a payment transaction. If we begin therapy, you will typically schedule one 50 minute session per week, however, we can schedule more frequent or longer sessions if needed. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, or unless you and I both agree that you were unable to attend due to emergency circumstances beyond your control.** Please note that insurance companies do not provide reimbursement for cancelled sessions. **To cancel, schedule or reschedule an appointment, please call the office: 480-447-3332.**

CONTACTING CB, LLC

Due to my work schedule, I am often not immediately available by telephone. Please leave a message on my business phone: 480-447-3332. I will make every effort to return your call the same day with the exception of weekends and holidays. If you are difficult to reach, please let me know when you are available. **If you are in crisis, unable to reach me and feel that you cannot wait for me to return your call, immediately contact your family physician, call or go to the nearest emergency room or call 911.**

LIMITS ON CONFIDENTIALTY

The law protects the privacy of all communications between a client and therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature related to this Agreement provides consent for those activities as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. All such consultations will be noted in your clinical record.
- You should be aware that I practice as an independent psychotherapist. I need to share protected health information (PHI) with office staff for administrative purposes. All office staff has been trained about protecting your privacy and has agreed not to release any information outside of my practice without permission.
- I also have contacts with legal, banking and accounting professionals. As required by HIPAA, I have an agreement with these firms that requires them to maintain the confidentiality of this data except as specifically allowed by contract or by law. If you wish, I can provide you with the names of these organizations.
- **If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.**

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychotherapist-client privilege law. We cannot provide any information without your or your

legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If I am asked to be involved in legal issues on your behalf my fees are \$300 per hour.

- If a government agency requests the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information in order to defend myself.
- If a client files a worker's compensation claim and I am providing services related to that claim, I must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission for the insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary in an attempt to protect others from harm and I may have to reveal information about a client's treatment. These situations are unusual in my practice:

- If I have reason to believe that a **child under 18**, who I have evaluated, is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that I file a report with the appropriate government agency, the Office of Child Protective Services and local police department. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that any **adult client who is either vulnerable and/or incapacitated** and who has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, a protective services worker. Once such a report is filed, I may be required to provide additional information.
- If a client **communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim**, and I believe that the patient has the intent and ability to carry out such a threat, I must take protective actions that may include notifying the potential victim, contacting the police or seeking hospitalization for the client.

If such a situation arises, I will make every effort to discuss it with you before taking any action and we will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

Please be aware that, pursuant to HIPAA, I keep Protected Health Information about you in 2 sets of professional records. One is your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways your problem impacts your life, your diagnosis, the goals we set for treatment, progress toward those goals, your medical and social history, our treatment history, past treatment records that I receive from other providers, reports of professional consultations, billing records, and reports that have been sent to anyone. Except in unusual circumstances that involve danger to you/others or where information has been supplied to us by others confidentially, you may examine and/or receive a copy of your Clinical Record, with a request in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of \$.20 per page. If the copying of requested records exceeds 5 minutes, there is an additional charge of \$3 for every 5 minutes of time it takes to copy the records. If I refuse your request for access to your records you have a right of review which I will discuss with you upon request.

In addition, I keep a set of Psychotherapy Notes. These Notes are for our own use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents/analysis of our conversations and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. While insurance companies can request a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive your Psychotherapy Notes unless I determine that such access is clinically contraindicated.

In the event of my death or incapacitation, I have appointed a professional colleague to act on my behalf to notify you and to make decisions about storing, releasing and/or disposing of my professional records: Sue Powers, LPC, 8115 E Indian Bend Suite 119, Scottsdale, AZ, 85250, 480-229-6674.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of PHI. These rights include requesting that we amend your record (must be made in writing), requesting restrictions of what information from your Clinical Record is disclosed to others, requesting an accounting of disclosures of PHI that you have neither consented to nor authorized, determining the location to which protected information disclosures are sent, having any complaints you make about my policies and procedures recorded in your records, and the right to a paper copy of this agreement. I will be happy to discuss any of these rights with you.

MINORS & PARENTS

Clients under 18 years of age (who are not emancipated) and their parents should be aware that the law may allow parents to examine their child's treatment records. **Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records.** If they agree, during treatment I will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication requires the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

Payment is due at the time of service at the session billing rates that were discussed and agreed to with you before booking your appointment with me. CB LLC accepts checks, VISA, Discover, MasterCard, or AMEX for professional therapy services. If a check is returned unpaid, you are responsible for full payment including the returned check fee. Delinquent accounts may be referred to a professional agency for collection. If an account cannot be settled within 60 days, I have the option of hiring a collection agency or small claims court that will require me to disclose confidential information. In most situations, the only information released is your name, the nature of services provided and the amount due. Credit

card receipts and copies of checks deposited to CB LLC financial institution are retained for 3 years.

INSURANCE REIMBURSEMENT

CB LLC does not accept insurance assignment. Therefore, it is your responsibility to bill your insurance company for direct reimbursement. I will provide you with a receipt for you to send to your insurance company directly. I do not and will not provide my Tax ID or any of your records to any insurance company. In order for us to set realistic treatment goals, it is important to evaluate your resources. Your health insurance policy may provide some coverage for mental health treatment. However, you are responsible for payment of my fees at the time of service. It is important that you find out exactly what mental health services your policy covers.

ELECTRONIC COMMUNICATION

There are inherent confidentiality and privacy risks along with limitations of electronic data exchange due to the nature of electronic communications. **There is no guarantee of confidentiality through e-mail correspondence or texting.** If you choose to communicate with me via e-mail or texting, by signing this agreement, you understand and acknowledge that any information including your name, email address, telephone number, or your correspondence with me is not guaranteed confidential. **If there is a confidentiality breach while communicating via electronic methods with me, you agree to release me from any responsibility for the breach.**

I HAVE REVIEWED THE INFORMATION ABOVE, UNDERSTAND IT, AND AGREE TO THESE UNDERSTANDINGS.

Client Signature _____ Date _____

Client Signature _____ Date _____