Elizabeth Marietti, MSW, LCSW
8040 E. Morgan Trail, Suite 9 Scottsdale, AZ 85258
(480) 607-7852

CLIENT INFORMATION FORM

Client's Name____DOB:___/___/___ SSN_____-_____-_____

Preferred Name______________________ Gender___ Marital Status________ Spouse's Name_____________

Address______________________________Apt #_____ City_________________________Zip Code__________

Home Phone____________________Cell__________________________Work____________________________

Email Address__________________________________ Employer_____________________________________

Primary Care Physician____Phone________________________

In emergency, notify____________________________Relationship__________________Phone_____________

Part II: Financial Policies, Agreements & Insurance Information: Please initial all that apply.

Person responsible for bill______________________________Relationship_____________SSN____-____-____

______I am not using insurance benefits and will pay out of pocket the rate of $250.00 for the initial session and $150.00 for each additional session. I understand that if I choose to bill insurance in the future, coverage of sessions will be effective only for dates of service after my insurance information is provided. Refunds will not be issued for any payments I have made before that date.

______I understand that all fees are due and payable at the time of service.

______I understand that the returned check fee is $25.00.

______I agree to give a 24-hour notice of cancellation in the event I cannot be at my appointment.

______I understand that the fee for a no-show or late cancellation (less than 24 hours' notice) is $75.00 and will be charged to my card on file.

______I am using my insurance benefits and have provided complete and current information. If there are any changes to my benefits or insurance plan, I will provide updated information within 10 days.

_____If my insurance denies coverage of services provided by Elizabeth Marietti, MSW, LCSW, I will be charged the standard rate of $150.00 per session. I understand that insurance plans DO NOT cover missed appointments.

PART III: Insurance Information: Provide this information if you are using insurance benefits.

Primary Insurance Information		
Insurance Company		
Policy/Subscriber ID#		Group #
Insurance Phone #	Employer	
Subscriber's Name		DOB
Subscriber SSN	Relationship to Client	
Secondary Insurance Information (if applicable)		
Insurance Company		Phone #
Policy #		Group #
Subscriber's Name		DOB
Subscriber's SSN	Relationship to Client	

I hereby assign my insurance benefits to be paid to Elizabeth Marietti, MSW, LCSW; and I authorize the release of all information required for the processing of insurance claims. Verification of benefits by telephone is not a guarantee of benefits but only an estimate given by the insurance carrier. Actual benefits are determined only when a claim is processed.

The client is responsible for any deductibles, co-pays, co-insurance, non-eligible or non-allowed charges according to your policy provisions and guidelines. It is the responsibility of the client to know your insurance policy provisions and guidelines. Contact your insurance company's Member Services Department if you have any questions.

PART IV: Credit Card on File/HSA Authorization: All patients provide this information.
______I authorize Elizabeth Marietti to charge the card below for any fees that are owed as listed in Part II at the time of service or after my insurance company processes my claims. I understand that some insurance companies are allowed up to 45 days to process all claims; therefore, the billing office for Elizabeth Marietti may charge these fees to my card up to 60 days after the date of service.

Card Type____________Card #____Exp. Date_____________ CSC code___________
(3 digits on back; AM EX has 4)

I have read and agree to the above policies:

____ ___________________________
Client Signature Date

____ ___________________________
Parent Signature (if client is a minor) Date

Elizabeth Marietti, MSW, LCSW
8040 E. Morgan Trail, Suite 9 Scottsdale, AZ 85258
(480) 607-7852 telephone

Informed Consent for Assessment and Treatment

Welcome to my counseling practice. I am committed to getting you whatever your outcome is for our time together. A counseling situation offers a unique relationship between the two of us. In order that we start our relationship in a healthy way, I have created this document to ensure that there are no misunderstandings about the various aspects of counseling and psychotherapy services.

Background and Services: I am a licensed clinical social worker in an independent counseling practice. My credentials include a Master's degree in Social Work; I am certified by the National Association of Social Workers. I am licensed by the Arizona Board of Behavioral Health Examiners.

I offer psychotherapy to children, adolescents, individuals, couples, and families in the area of mental health, relationships, adjustment, personal development, and career and business issues. Clients who present in counseling with substance abuse dependence, eating disorders, sexually abusive or violent behaviors, severe mental disorders, 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 the client's needs or desires in therapy are not a good match for my skills or experience.

Although I share office space with other therapists, my practice is independent from them. They do not provide care or treatment for my clients, and I do not provide care and treatment for their clients.

Financial: Payment is expected at the time 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. Currently, the fee for an initial assessment is $135; the fee for a 45-50 minute counseling session is $125. 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 services have been rendered. You have the right to be informed of all fees that you are required to pay, and my refund and collection policies. Please discuss these with me if you have a concern.

Insurance: I am a preferred provider for a number of health plans in this locality. If you are using one of these plans to pay for your treatment, the terms that govern the plan will apply (i.e., co-payments, deductibles, insurance filing, etc.). If you are using another insurance program for which I am not a covered provider, I will supply you with a superbill that you can submit to your insurance company for reimbursement. However, payment for services is ultimately the responsibility of the client, not the insurance company. Please discuss this with me if you have questions or concerns about using your insurance benefits.

If you are covered by two insurance plans (primary and secondary), I will bill your primary plan, assuming that I am a covered provider under the primary plan. If I am not a provider under your primary plan, you will be required to pay the fees out of pocket, and you will receive a superbill as a receipt that you can file with your

secondary insurance company. In all cases, the client is responsible for dealing with the secondary insurance company's paperwork and filing.

If you are over 65, or otherwise eligible for Medicare, I am a Medicare provider.

Your insurance company or managed care company may limit the number of sessions based on their assessment of medical necessity or other factors. Their termination may or may not match what you want or need in treatment. In the event that your insurance will not authorize additional sessions or you exhaust the sessions that your insurance provides, you understand that you will be responsible to pay for additional services rendered.

Using a third party to pay for counseling implies that some information will be released to them in order to obtain payment for services.

Availability of services: My practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to your community's emergency services (911) or to the local hotlines (Empact: (480) 784-1500; Banner Help Line: (602) 254-4357; ValueOptions: (602) 222-9444). Established clients with an urgent need to make contact with me may call me, but an immediate response is not guaranteed. A quick and immediate response in one situation does not constitute a commitment of rapid response in another situation.

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, if you need to cancel, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment. **You will be billed for appointments you fail to cancel in accordance with this policy. Currently, the late-cancellation fee is $75 and will be billed to your credit card on file. Repeated late cancellations or missed appointments will be billed at the full fee of $125.** Missed appointments cannot be billed to your insurance.

Appointment availability varies with my client load. High-demand appointments (off hours, late afternoons) are likely to be sporadic in their availability. I reserve the right to limit my commitments of high-demand appointment times to any particular client in order to meet the needs of all my clients and to balance my workload.

Privacy, confidentiality, and records: Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statues. The most common of these exceptions are when there is a real or potential life-or-death emergency, when the Court issues a subpoena, or when child/elder abuse or neglect is involved. There may be a situation in which I will consult with another professional about your case. While no identifying information is released, the dynamics of the problem and the people are discussed, along with treatment approaches and methods.

It is important to be aware that I use a number of electronic tools in my practice, including computers and the Internet, email, fax machines, telephones, and a cell phone. I may use those 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 will typically 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.

There are also numerous other circumstances when information may be released, including but not limited to, when disclosure is required by the Arizona Board of Behavioral Health Examiners; when a lawsuit is filed against me; to comply with Worker Compensation laws; to comply with the USA Patriot Act; and to comply with other federal, state, or local laws. The rules governing confidentiality, privacy, and records are complex.

In the event of my death, retirement, or incapacity, the records for my clients who are actively receiving services (seen within the past month) will be given to one or more local behavioral health professionals to facilitate continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by a "records custodian," which may be an individual or a company. The custodian will be responsible for satisfying records' requests and destroying records when the legal time frames for records' retention have been satisfied.

<u>Purpose, limitations, and risks of treatment.</u> Like most endeavors in the helping professions, counseling is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that may result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy may result in changes that were not your original intention. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. Of course, the potential for divorce is always a risk in marital counseling.

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.

<u>Treatment process and rights.</u> Your counseling will begin with one or more sessions devoted to an initial assessment so that I may obtain a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal.

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 become 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 the client's 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.**

Our relationship: The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained.

If there is ever a time when you believe that I have treated you unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings may inadvertently result in hurt feelings. As soon as possible, I want to address any issues, including administrative or financial issues, that might get in the way of your therapy.

Consent for evaluation and treatment: Consent is hereby given for evaluation and treatment under the terms described in this consent document. I acknowledge that I have received a copy of this Informed Consent Agreement. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

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 therapist's use only—verification that client has read and understands informed consent document.
Therapist's signature___________________________________Date________________

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Acknowledgment of Receipt of Notice of Privacy Practices

To our patients:

The privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information and your rights in this information. We ask you to review our Notice of Privacy Practices that describe our legal duties with respect to your health care information.

<u>How We Use Your Health Care Information:</u>

In summary, we use information to

- Provide treatment to you.
- Ensure appropriate payment for the treatment we provide.
- Monitor the quality of our patients' treatment.

We take great care to safeguard your personal health information and to ensure its accuracy:

- We limit employee access to personal health information to those who need to know this information in order to serve patient relationships. Employees are educated about the importance of privacy in accordance with our Notice of Privacy Practices.
- We maintain physical, electronic and procedural safeguards that comply with all applicable regulatory standards to guard your personal health information.
- We strive to maintain complete, current and accurate information about you and your accounts. If you request a correction to our records, we will respond in a timely manner.

<u>Your Information Rights:</u>

We create a record of the care we give you. You have the following rights to this information:

- You have the right to know how we use your health information, who we can give it to, and your rights in this information. (Please see our Notice of Privacy Practices.)
- You have the right to ask us to restrict uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.
- You have the right to confidential communication of your health information. For example, you can ask for a conversation to be held in private or for us to send a copy of your bill to a different address.
- You have the right to look at and get a copy of information in our record unless your provider has indicated this would be harmful to you or someone else.
- You have the right to request that our records be amended if we agree it is inaccurate or incomplete.
- You have the right to ask us for a list of when we have disclosed your health information to someone other than those treating you, or handling your bills, or for internal operation, or when you have authorized release of information.

Please sign below that you have received our Notice of Privacy Practices. If you have questions, please speak to your provider.

Printed Name____

Signature____Date_______________

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Client Rights

All clients shall be afforded the following basic rights:

1. The right to treatment and services under conditions that support the client's personal history. Such liberty will be restricted only as necessary to comply with treatment needs.
2. The right to an explanation of all aspects of one's condition and treatment.
3. The right to an individualized written treatment plan with periodic review and reassessment and revision of needs. The plan will include a description of the services necessary to complete the goals and objectives of the plan. The client has the right to participate in the development and revision of the treatment plan.
4. The right to a humane treatment environment that affords protection from harm, appropriate privacy, and freedom from verbal and physical abuse.
5. The right to confidentiality of records. Confidentiality may be waived if:
    - Client is a danger to self or others (i.e., threatens grave bodily harm, discusses plans to terminate his/her life).
    - Client describes a situation in which the therapist has reason to suspect child abuse or neglect, sexual abuse, or abuse of a senior citizen.
    - Client's records are subpoenaed and a judge enforces this action.
6. The right to access, upon request, one's own records in accordance with state law and as outlined in Notice of Privacy Practices.
7. The right to be informed of all rights in one's primary language.
8. The right to legal counsel and all other requirements of due process.
9. The right not to be subjected to remarks that ridicule self or others.
10. The right to assert grievances with respect to infringement of these rights. This includes the right to have such grievances considered in a fair, timely, and impartial procedure.
11. The right of access to an advocate in order to understand, exercise, and protect one's rights.
12. The right to be informed in advance of charges for services.
13. The right to all existing services and referral to other providers of behavioral health services, as appropriate, without discrimination because of race, creed, color, gender, age, disability, or marital status.
14. In the event of my death or incapacity, the records for my clients actively receiving services (seen without the past month) will be given to one or more local behavioral health professionals to facilitate the continuation of treatment. In such a situation, a client has the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by a "records custodian," which may be an individual or company. The custodian will be responsible for satisfying requests for records and destroying records when the legal time frames for record retention have been satisfied.

Print Client's Name____

Signature of Client/Parent/Legal Guardian____

Date____

Medical History Form

Client Name____DOB_______________

- Are you allergic to any medications (have you experienced adverse reactions to any medications, over the counter or prescription)? ☐ no ☐ yes

  Describe the reaction:____
- Do you have any other allergies (food, pollens, pet dander, environmental? ☐ no ☐ yes
- Are you currently under the care of a physician for any medical problems or currently experiencing any medical problems about which you are concerned? ☐ no ☐ yes If yes, please list below:

Problem	**Onset of Symptoms**	**Treating Physician**

- Are you currently taking any type of medication? Please list prescribed and over-the- counter (OTC) drugs.

Drug Name	**Dose and Date**	**Prescribing Physician or OTC**

- Have you been treated for any significant medical problems in the past? ☐ no ☐ yes

  Describe____

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Authorization for Exchange of Information with Primary Care Physician (PCP)

I, ____, hereby authorize Elizabeth Marietti, LCSW,
(Printed Name of Patient or Guardian)
to disclose the information checked below related to the treatment of__________________________
(Patient's Name)
to my Primary Care Physician (PCP)____
(Name of PCP)

______Mental Health Information _____Substance Abuse Information _____Medical Information including HIV/AIDS

This information may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of authorization, further release of information shall cease immediately. This release of information expires in _________________ days following completion or termination of treatment.

Executed this ___________ Day of ________________________________ Year____________________

____ ________________________________
Patient's Signature Date

____ ________________________
Guardian's Signature Date

To the Recipient of Confidential Information

If the information disclosed to you relates to substance abuse, these records are protected by federal law. Federal regulation (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. Federal Regulations restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient records.

Coordination of Care