

Dyer Counseling & Psychology, PLLC

9821 E. Bell Rd., Ste. 100
Scottsdale, AZ. 85260
480-290-0179

Client Information Form 1

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes No

How did this person explain how I might be of help to you? _____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation Protestant Catholic Jewish Islamic Buddhist Hindu

Other (specify): _____

Involvement: None Some/irregular Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way
you identify yourself and consider important: _____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

E. Your current employer

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

| Dates | | Schools | Special classes? Adjustment to school | Did you graduate? |
|-------|----|---------|---------------------------------------|-------------------|
| From | To | | | |

H. Employment and military experiences

| Dates | | Name of employers | Job title or duties | Reason for leaving |
|-------|----|-------------------|---------------------|--------------------|
| From | To | | | |

I. Family-of-origin history

| Relative | Name | Current age (or age at death) | Illnesses (or cause of death) | Education | Occupation |
|----------|------|----------------------------------|----------------------------------|-----------|------------|
|----------|------|----------------------------------|----------------------------------|-----------|------------|

Father

Mother

Brothers

Sisters

Others

J. Marital/relationship history

| | Spouse's name | Spouse's age | Your age | Your age when divorced | Has spouse remarried? |
|--------|---------------|--------------|----------|------------------------|-----------------------|
| First | | | | | |
| Second | | | | | |
| Third | | | | | |

K. Significant non-marital relationships

| | Name of other person | Person's age | Your age | Your age when ended | Reason(s) for ending |
|---------|----------------------|--------------|----------|---------------------|----------------------|
| First | | | | | |
| Second | | | | | |
| Third | | | | | |
| Current | | | | | |

L. Children Indicate those from a previous marriage or relationship with "P" in the last column.

| Name | Current age | Sex | School | Grade | Adjustment problems? | P? |
|------|-------------|-----|--------|-------|----------------------|----|
| | | | | | | |

M. Is there any other information you think we should know?

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Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- I have no problem or concern bringing me here
- Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety, nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Codependence
- Confusion
- Compulsions
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use—prescription medications, over-the-counter medications, street drugs
- Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce

Adult Checklist of Concerns (p. 2 of 3)

- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Housework/chores--quality, schedules, sharing duties
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Pain, chronic
- Panic or anxiety attacks
- Parenting, child management, single parenthood
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems (with friends, with relatives, or at work)
- School problems (see also "Career concerns ...")
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems--too much, too little, insomnia, nightmares
- Smoking and tobacco use

Adult Checklist of Concerns (p. 3 of 3)

- Spiritual, religious, moral, ethical issues
 - Stress, relaxation, stress management, stress disorders, tension
 - Suspiciousness, distrust
 - Suicidal thoughts
 - Temper problems, self-control, low frustration tolerance
 - Thought disorganization and confusion
 - Threats, violence
 - Weight and diet issues
 - Withdrawal, isolating
 - Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
 - Other concerns or issues: _____
-

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.



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Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)

Date

Printed name

Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Deborah E. Dyer, Ph.D.
Licensed Psychologist

Date

Copy accepted by client Copy kept by therapist

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What You Should Know about Confidentiality in Therapy

I will treat what you tell me with great care. My professional ethics (that is, my profession's rules about values and moral matters) and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the “confidentiality” of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. There are some times when the law requires me to tell things to others. There are also some other limits on our confidentiality. We need to discuss these, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules now, so that you don't tell me something as a “secret” that I cannot keep secret. So please read these pages carefully and keep this copy. At our next meeting, we can discuss any questions you might have.

- 1) **When you or other persons are in physical danger, the law requires me to tell others about it. Specifically:**
 - a) If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person. I may have to tell the person and the police, or perhaps try to have you put in a hospital.
 - b) If you seriously threaten or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to.
 - c) In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterwards.
 - d) If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency. To “abuse” means to neglect, hurt, or sexually molest another person. I do not have any legal power to investigate the situation to find out all the facts. The state agency will investigate. If this might be your situation, we should discuss the legal aspects in detail before you tell me anything about these topics. You may also want to talk to your lawyer.

In any of these situations, I would reveal only the information that is needed to protect you or the other person. I would not tell everything you have told me.

- 2) **In general, if you become involved in a court case or proceeding, you can prevent me from testifying in court about what you have told me. This is called “privilege,” and it is your choice to prevent me from testifying or to allow me to do so. However, there are some situations where a judge or court may require me to testify:**
 - a) In child custody or adoption proceedings, where your fitness as a parent is questioned or in doubt.
 - b) In cases where your emotional or mental condition is important information for a court's decision.
 - c) During a malpractice case or an investigation of me or another therapist by a professional group.
 - d) In a civil commitment hearing to decide if you will be admitted to or continued in a psychiatric hospital.
 - e) When you are seeing me for court-ordered evaluations or treatment. In this case we need to discuss confidentiality fully, because you don't have to tell me what you don't want the court to find out through my report.
 - f) If you were sent to me for an evaluation by worker's compensation or Social Security disability, I will be sending my report to a representative of that agency and it can contain anything that you tell me.
- 3) **There are a few other things you must know about confidentiality and your treatment:**
 - a) I may sometimes consult (talk) with another professional about your treatment. This other person is also required by professional ethics to keep your information confidential. Likewise, when I am out of town or unavailable, another therapist will be available to help my clients. I must give him or her some information about my clients, like you.
 - b) I am required to keep records of your treatment, such as the notes I take when we meet. You have a right to review these records with me. If something in the record might seriously upset you, I may leave it out, but I will fully explain my reasons to you.
- 4) **Here is what you need to know about confidentiality in regard to insurance and money matters:**
 - a) If you use your health insurance to pay part of my fees, the insurance company, the managed care organization, or perhaps your employer's benefits office will require me to provide information about your functioning in many

areas of your life, your social and psychological history, and your current symptoms. I will also be required to provide a treatment plan for your problems and information on how you are doing in therapy.

- b) I usually give you my bill with any other forms needed, and ask you to send these to your insurance company to file a claim for your benefits. That way, you can see what the company will know about our therapy. It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information after it leaves my office. You cannot be required to release more information just to get payments.
 - c) If you have been sent to me by your employer's employee assistance program, the program's staffers may require some information. Again, I believe that they will act morally and legally, but I cannot control who sees this information at their offices. If this is your situation, let us fully discuss my agreement with your employer or the program before we talk further.
 - d) If your account with me is unpaid and we have not arranged a payment plan, I can use legal means to get paid. The only information I will give to the court, a collection agency, or a lawyer will be your name and address, the dates we met for professional services, and the amount due to me.
- 5) **Children and families create some special confidentiality questions.**
- a) When I treat children under the age of about 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, most of the details in things they tell me will be treated as confidential. However, parents or guardians do have the right to general information, including how therapy is going. They need to be able to make well informed decisions about therapy. I may also have to tell parents or guardians some information about other family members that I am told, especially if these others' actions put them or others in any danger.
 - b) In cases where I treat several members of a family (parents and children or other relatives), the confidentiality situation can become very complicated. I may have different duties toward different family members. At the start of our treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist.
 - c) If you tell me something your spouse does not know, and not knowing this could harm him or her, I cannot promise to keep it confidential. I will work with you to decide on the best long-term way to handle situations like this.
 - d) If you and your spouse have a custody dispute I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluations.
 - e) If you are seeing me for marriage counseling, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify.
 - f) At the start of family treatment, we must also specify which members of the family must sign a release form for the common record I create in the therapy or therapies. (See point 7b, below.)
- 6) **Confidentiality in group therapy is also a special situation.** In group therapy, the other members of the group are not therapists. They do not have the same ethics and laws that I have to work under. You cannot be certain that they will always keep what you say in the group confidential.
- 7) Finally, here are a few other points:
- a) I will not record our therapy sessions on audiotape or videotape without your written permission.
 - b) If you want me to send information about our therapy to someone else, you must sign a "release-of-records" form. I have copies you can see, so you will know what is involved.
 - c) Any information that you tell me and also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The laws and rules on confidentiality are complicated. Please bear in mind that I am not able to give you legal advice. If you have special or unusual concerns, and so need special advice, I strongly suggest that you talk to a lawyer to protect your interests legally and to act in your best interests.

The signatures here show that we each have read, discussed, understand, and agree to abide by the points presented above.

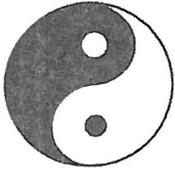
Signature of client (or person acting for client)

Date

Printed name

Signature of therapist

Date



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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at 480-290-0129.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of client or his or her personal representative Date

Printed name of client or personal representative Relationship to the client

Description of personal representative's authority

Signature of authorized representative of this office or practice

Date of NPP: _____

Copy given to the client/parent/personal representative