Steve Barcanic, MA, LPC
Creative Counseling Solutions, LLC
7360 N. La Cholla Blvd.
Tucson, AZ 85741
520-531-1934

Demographic Information

Who referred you? _____

Child's Name: _____

DOB: _____ Age: _____

Parents/Guardians: _____
Address: _____
City, State, Zip _____

Phone: Home: _____
Cell: _____
Work: _____

Email Address: _____

Emergency Contact: _____

School: _____
Grade: _____

Is your child prescribed medication?: Yes___ No ___
If yes, medication name and dose: _____
_____

Counseling Goals: _____
_____
_____

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Consent for Treatment of a Minor

I, _____, hereby grant permission for Steve Barcanic to use routine counseling services as may be deemed necessary or advisable for the treatment of my son/daughter, _____. I understand that there is no guarantee that these services will prove beneficial to me, my son/daughter, or other family members.

Even though all information gathered in the course of my counseling is confidential, this confidentiality is not absolute. In the case of medical emergency, child abuse or neglect, court order, or where otherwise legally required, confidential information may be released.

Client Name: _____

Parent or Guardian Signature:_____ Date: _____

Privacy Practice Notification

By signing below, I acknowledged that I have received a copy of the Privacy Practices for this office:

Patient, Parent, or Guardian: _____ Date: _____

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Fee Agreement

I understand that fees for counseling services are $110 per 45-50 minute session, and that payment is due at the time services are delivered.
If applicable, I am choosing to pay for counseling services through my insurance plan.
My insurance company is: _____and my copay is $_____.

Cancellations, missed appointments, and rescheduling

Except in cases of illness or emergency, if you miss your appointment without notice or cancel with less than 24 hour notice, you will be billed a $50 missed appointment fee.

Additionally, counseling services may be discontinued if a pattern of missed appointments occurs.

Patient, Parent, or Guardian: _____ Date: _____

Structure of Counseling Sessions

Counseling appointments are 45-50 minutes in duration. This is an industry standard, and is also the authorized amount of time allocated by most insurance companies. If you will be leaving the office while your child is attending the appointment, please be sure to return in a timely manner so that scheduling and payment can be completed. Your cooperation is appreciated.

As a parent or guardian, you will always have the opportunity to discuss any concerns privately with me, at the start of the appointment time. You will also be updated regularly as to counseling goals and progress. If you have any additional questions or concerns regarding the counseling process, please do not hesitate to let me know.

Patient, Parent, or Guardian: _____ Date: _____

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Release of information

(Please complete and sign only if you are requesting communication between Steve Barcanic and another therapist, physician, school personnel, or other service provider)

Client Name: _____ DOB: _____
Client Address: _____Phone: _____

I, the undersigned, consent to the release of information

from: Steve Barcanic, MA, LPC
7360 N. La Cholla Blvd.
Tucson, AZ. 85741

To: _____
Name

_____
Address

_____
City, State, Zip

Information to be released:

_____ Medical Progress Notes
_____ School Records (Academic and Behavioral)
_____ Counseling Summary
_____ Psychological Testing
_____ Mental Health Diagnosis/Treatment Information

From (begin date) _____ to (end date) _____.

Signature of Patient: _____
Date: _____

Signature of Parent/Guardian: _____
Date: _____

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Insurance Information:

Patient Behavioral Health Insurance Carrier: _____

Insurance company phone number: _____

Insurance company address: _____

Identification Number: _____

Primary Group Number: _____

Are you required to have an authorization? Yes No

Authorization number: _____

Are you the primary cardholder? Yes No

If not, name of primary cardholder: _____

Your relationship to patient: _____

Primary cardholder DOB: _____

Cardholder Employer: _____

Cardholder phone: Home: _____

Cell: _____

Please read and sign:
I authorize the release of any of my medical, psychiatric, or other information necessary to process my claim and to provide information to another healthcare provider when necessary to coordinate treatment. I also authorize payment of medical benefits to the provider for services rendered. ***I fully understand that if my insurance denies payment for any services defined as a non-covered service, I will be responsible for any amount due.***

Signature of Patient, Parent, or Guardian: _____ Date: _____

For Office Use Only

Date	Type of service	fee	method of pmt	notes

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Developmental History

Name of Patient:
Patient's Date of Birth:
Names of Parents:
Today's Date:

(Please print clearly)

Presenting Problem:

What are your primary concerns that lead you to pursue counseling?

How long have you been concerned about these issues?

What has been done so far to address these concerns?

What are your child's strengths and interests?

Family History:

Have there been any family issues that have been traumatic for your child? (Death of a loved one, frequent moves or changes of school, domestic violence, divorce, etc?)

If parents are divorced, please describe custody and visitation between parents:

If your child has siblings, please briefly describe their relationship:
Please briefly describe your child's relationship with his/her parents:

What behaviors do you see in your child that require discipline?

What are your discipline strategies?

Are there any family members that are involved in the care of your child? If so, do you have any concerns regarding the interactions/relationship of this person and your child?

Early Childhood Development:

Are you aware of any prenatal problems?

Where there any physical or developmental problems your child experienced as an infant of toddler?

Did your child experience any injuries or illnesses in the first 3 years of life that required hospitalization? If so, please explain:

Do you have any concerns regarding your child's sleep patterns?

…Eating patterns?
…Anger management skills?

Child's Current Health:

How is your child's overall health?

Does your child have any medical needs? If so, please explain:

Please list any medications your child is currently prescribed:

If your child is prescribed medication, please describe any concerns you have over his/her willingness to take the medication:

Who is your child's doctor?

Education History:

Current School: Grade:
Teacher (if applicable):

Previous schools:

Do you have any a) academic concerns? Please explain:

b) behavioral concerns?

c) social concerns (being bullied, lack of friends, etc)?

What does your child like about school?

What does your child dislike?

Does your child have a 504 plan or IEP?

Counseling and Mental Health History:

Has your child or family received counseling in the past? If so, who was the counselor, when did the counseling take place, and what were the concerns addressed in counseling?

Please describe the results of past counseling:

Do you feel your child currently experiences depression or anxiety or stress? Please describe:

Have you ever had concerns that your child could be considering suicide? If so, please explain. Please include the time period of these concerns and steps taken to support your child:

Please describe any concerns regarding your child's self-esteem:

Additional information you believe might be helpful, or other areas in which you are concerned:

Creative Counseling Solutions, LLC (CCS)

Notice of Privacy Practices

Effective January 12, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Duty to Safeguard Your Protected Health Information.

"Protected Health Information" or "PHI" means individually identifiable information about your past, present, or future health or condition; the provision of behavioral health care to you; or payment for the behavioral health care; and that is included in enrollment, payment, claims adjudication, and other records maintained by CCS or used to make decisions about you.

CCS must safeguard the privacy of your PHI. The purpose of this Notice of Privacy Practices is to provide you with information about the legal duties and privacy practices of CCS regarding your PHI. CCS may change its policies at any time, however, before any material revisions to our policies are made, we will change our Notice of Privacy Practices and deliver the revised Notice as required by law. The revised Notice will be effective for all PHI that we maintain at that time. Except when required by law, a material change to any term of the Notice may not be implemented before the effective date of the Notice that contains the material change.

How We May Use and Disclose Your Protected Health Information.

CCS uses or discloses PHI for a variety of reasons. We have a right, with some limitations, to use or disclose your PHI for purposes of treatment, payment, and behavioral health care operations. For other uses or disclosures, CCS must have your written authorization, unless required by law. For those situations where a written authorization is required and you have provided it to CCS, you do have the right to revoke your authorization at any time after providing it. The revocation of your authorization must be in writing to CCS/Steve Barcanic, MA, LPC. If we disclose your PHI to a business associate in order for that entity to perform a function on our behalf, we must have in place an agreement signed by the business associate requiring the business associate and its subcontractors to extend the same degree of privacy protection to your PHI that CCS must apply.

The following pages offer more description and some examples of our potential uses or disclosures of your PHI. If a use or disclosure of PHI is not described in this Notice of Privacy Practices, we will not make that use or disclosure without your written authorization.

Uses and Disclosures Relating to Treatment, Payment, or Behavioral Health Care Operations.

Generally, we may use or disclose your PHI as follows:

For treatment: We may use or disclose your PHI to administer, coordinate, and manage your behavioral health care and any related services. For example, some of your PHI may be shared with applicable CCS staff. Some of your PHI also may be shared with outside entities that perform services related to your treatment. We may communicate with health professionals to plan your care and treatment or for consultation. This will only occur with your written consent.

For payment: We may use or disclose your PHI in order to bill and collect payment for your behavioral health care services delivered to you. For example, we may release portions of your PHI to third-party payers, including applicable insurance companies.

For health oversight activities: We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities may include monitoring, audits, investigations, inspections, and licensing.

Relating to decedents: We may disclose PHI related to an individual's death to coroners, medical examiners, funeral directors, or organ procurement organizations (with regard to anatomical gifts). Unless an individual indicated otherwise before death, we also may disclose PHI related to the individual's death to family members, friends, or others who were involved in the individual's care or payment for care before death.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For specific government functions: We may disclose PHI of military personnel and veterans in certain situations. Other government related disclosures may include information disclosed to Human Rights Committees, the Sexually Violent Persons Program, correctional facilities and other law enforcement custodial situations, and to government benefit programs (for purposes of eligibility and enrollment). We also may disclose your PHI for national security reasons, such as protection of the President.

Uses and Disclosures Requiring Your Written Authorization.
We may not use or disclose your PHI without your written authorization if the use or disclosure would constitute a sale of PHI. We may not use or disclose your PHI for marketing purposes without your written authorization. Most uses and disclosures of your psychotherapy notes will require your written authorization. There may be other uses and disclosures of your PHI for which we will seek your written authorization.

Uses and Disclosures of PHI Not Requiring Authorization.
Unless otherwise prohibited by law, we may use or disclose your PHI without consent or authorization in the following circumstances:

When required by law: We may disclose PHI as required by state or federal law. Examples include disclosures: 1) for reporting suspected abuse, neglect, exploitation, or domestic violence; 2) related to suspected criminal activity; 3) in response to a court order or other legal process, judicial or administrative proceedings, or certain other law enforcement situations; 4) to personal representatives; and 5) for workers' compensation purposes. We must also disclose PHI to authorities that monitor compliance with the privacy requirements described in this Notice.

For public health activities: We may disclose PHI for public health activities. Examples include when we are required to collect information related to conducting public health surveillance, public health investigations, or public health interventions or related to reporting to the public health authority vital events such as birth or death.

Uses and Disclosures to Which You Have an Opportunity to Object.
Unless otherwise prohibited by law and provided you are informed in advance about the disclosure and do not object, we may disclose a limited amount of your PHI as follows:

To families, friends or others involved in your care: We may share with these people information directly related to their involvement in your care, or payment for your care. We also may share PHI with these people to notify them about your location, general condition, or death.

Your Rights Regarding Your Protected Health Information.
You have the following rights relating to your Protected Health Information:

Right to Request Restrictions: You have the right to request that we restrict use or disclosure of your PHI to carry out treatment, payment, health care operations, or communications with family, friends**,** or other individuals. We are not required to agree to a restriction. We cannot agree to limit uses or disclosures that are required by law. Your request must be made in writing to CCS/Steve Barcanic, MA, LPC.

Right to Request Conditions on Providing Confidential Communications: You have the right to request that we send communications that contain PHI by alternative means or to alternative locations. We must accommodate your request if it is reasonable and you clearly state that the disclosure of all or part of that information could endanger you. Your request must be made in writing to CCS/Steve Barcanic, MA, LPC.

Right to Inspect and Copy: You have the right to inspect and copy behavioral health information that we maintain about you. Your request must be made in writing to CCS/Steve Barcanic, MA, LPC. If copies are requested or if you agree to a summary or explanation of such information, we may charge a reasonable, cost-based fee for the costs of copying, including labor, postage; and preparation cost of an explanation or

summary. We may deny your request to inspect and copy in certain circumstances as defined by law.

Right to Request an Amendment: For as long as your behavioral health information is maintained, you have the right to request that an amendment be made to such records. The request must be made in writing to CCS/Steve Barcanic, MA, LPC. Your request must include the reason or reasons that support your request. We may deny your request for an amendment if we determine that the record that is the subject of the request was not created by us, is not part of the designated record set, is not available for inspection as specified by law, or is accurate and complete.

Right to Receive an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your behavioral health information. This does not include disclosures made: to carry out treatment, payment, and health care operations; to you; to family, friends, or others involved in your care; for national security or intelligence purposes; or to correctional institutions or law enforcement officials.

Right to receive this notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

Right to be notified of a breach of your PHI. In the event of a breach of your PHI that is created, received, or maintained by CCS/Steve Barcanic, MA, LPC, you have the right to receive written notification.