Believe Counseling Services (BCS) Intake Packet

CLIENT INFORMATION

To use this fill-in form click on the field and TAB to the next field.

Client Name:	First Name Last Name
Preferred name:	Preferred Name
Preferred gender pronoun: she/her, he/him, they/them, it, etc.	Preferred gender pronoun
Date of Birth	Enter date of birth
Address:	Street Apt #City, State00000
Home Phone Number:	0000000000
------Do I have your permission to leave a voice message at your home?	Yes or No
Cell Phone Number:	0000000000
------Do I have your permission to leave a voice message at your cell?	Yes or No
------Do I have your permission to send a text message at your cell?	Yes or No
E-Mail Address:	e-mail address
Do I have your permission to send you an e-mail?	Yes or No
Emergency Contact (name/relationship/number):	Full name/relationship/10 digit phone number of emergency contact
Primary Care Physician/Phone:	Primary Care Physician and phone number
Psychiatric Prescriber/phone:	Psychiatrist phone number
Medication(s) currently taking (including non-prescription and supplements):	List all and separate with a comma or period.
How did you hear of us?	How did you hear of us?
Signature: (if printing. if uploading an electronic signature opportunity will be provided.)	Date:MM/DD/YEAR

INSURANCE VERIFICATION

A copy of the front and back of your insurance card is required. I will need to see your driver's license. This is to comply with best practices and to eliminate insurance fraud. *If completing electronically, you may upload clear images.*

Name of Client:	Client Name
Date of Birth:	Date of Birth
Relationship to Insured:	Click here to enter text.
ID#/Group Number:	Click here to enter text.
*Name of Insured (**if different from client**):	Name of Insured
Date of Birth:	Date of Birth
Relationship to **Client**:	Click here to enter text.
ID Number/Group Number:	Insurance number and Group Number
Employer Name and Phone Number:	Click here to enter text.
Insurance Name/Address/Phone Number:	Click here to enter text.
Effective Date of Coverage:	Click here to enter text.
Annual Deductible/Out of Pocket Amounts:	Click here to enter text.
Deductible met for this Year? Yes No Amount Remaining	Click here to enter text.
Deductible/OOP:	Click here to enter text.
Number of Visits:	Click here to enter text.
Co-Pay:	Click here to enter text.
Authorization Number:	Click here to enter text.
Authorization and other Details:	Click here to enter text.
Signature: (if printing. if uploading an electronic signature opportunity will be provided.)	Date:MM/DD/YEAR

Some questions you may want to ask your insurance carrier:

• Do I have mental health benefits?	• What is my deductible and has it been met?
• How many sessions per calendar year does my plan cover?	• How much does my plan cover for an out-of-network provider?
• What is the coverage amount per therapy session?	• Is approval required from my primary care physician?

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ACKNOWLEDGMENTS AND RECEIPTS OF INFORMED CONSENTS
(BCS COPY)

Acknowledgment and Receipt of Informed Consent Part I:
NOTICE OF PRIVACY PRACTICES (Pages 6-7)
I certify that I have read and understand, and that I have received a copy of the Notice of Privacy Practices (HIPAA).

Click here to enter text.	Initial here to indicate receipt	Date:MM/DD/YEAR

Acknowledgment and Receipt of Informed Consent Part II:
TPO: TREATMENT-PAYMENT-OPERATIONS (Page 8)
I certify that I have read and understand, and that I have received a copy of the TPO Disclosures.

Click here to enter text.	Initial here to indicate receipt	Date:MM/DD/YEAR

Acknowledgment and Receipt of Informed Consent Part III: BASIC MENTAL HEALTH CARE GUIDELINES (Page 9)

I certify that I have read and understand, and that I have received a copy of the Mental Health Guidelines. I also certify that I understand that the law upon which these guidelines are based is currently on hold.

Click here to enter text.	Initial here to indicate receipt	Date:MM/DD/YEAR

Acknowledgment and Receipt of Informed Consent Part IV: MACRO COMMUNITY (Pages 10-11)

I certify that I have read and understand, and that I have received a copy of the Macro Community Informed Consent. I also understand that the possibility for potential Boundary-Crossing is increased between me and a BCS staff member within a particular macro-community. We have discussed this possibility and developed a plan. Given this information, I hereby agree to participate in psychotherapeutic services at BCS. Potential Macro Communities Identified:

_____

Signature: (if printing. if uploading an electronic signature opportunity will be provided.)	Date:MM/DD/YEAR

Click here to enter text.	(if completing electronically) Initial here that you have received all of the above electronically.

Believe Counseling Services Intake Packet

INFORMED CONSENT PART V: CONSENT TO TREAT (BCS COPY)

I understand that Believe Counseling Services, LLC provides psychotherapeutic/clinical services to persons who present voluntarily for intervention. I understand that BCS specializes in working with Personality Disordered Individuals, and that clinical interventions will frequently focus on cognitive and behavioral insight building. I understand that BCS typically only works with adults. I also understand that many individuals who present for treatment at BCS have unusual issues, and I agree to practice a non-judgmental stance on all of them, as well as myself. I understand that even though she may be aware of and support other interventions, my therapist will only use methods with me in which she is sufficiently trained, and that are empirically proven. I understand that my therapist meets with other therapists for professional consultation on a regular basis, and that my case may be discussed to enhance the likelihood of my clinical success. I also understand that the methods that will be used include, but are not limited to Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Rational Emotive Behavior Therapy, Behaviorism and Shaping, Brief Therapy, Strategic Therapy, Rogerian Techniques, Freudian Analysis Techniques, Gestalt Techniques, Motivational Interviewing, Relaxation Techniques, Use of Metaphors, Transactional Analysis, and Neuroscientific Education.

♣I understand I have the right and obligation to participate in the treatment planning so that the therapy goes in a direction so as to resolve the issues I am presenting, and I have the right to change this direction at any time.

♣I understand I have the right to ask questions, investigate and/or refuse any treatment.

♣I understand that I will have an opportunity to be informed of and discuss my diagnosis, if one applies.

♣I understand that services are based on availability, and while every effort will be made to accommodate my needs, ultimately, appointment availability may be limited.

♣I understand that BCS does NOT work with several issues, including but not limited to: Psychotic Symptoms, Narcissistic Personality Disorders and Traits, Antisocial Personality Disorders and Traits, Eating Disorders, and Sociopathy. If it is determined that symptoms of these disorders are driving my behaviors at any time, services will be discontinued in good faith that another provider would be more effective for me.

♣I agree to actively and collaboratively work on discontinuing ALL thoughts, urges, and behaviors that are associated with self-harm and suicide.

♣I understand that I must provide written consent to tape or film sessions, and I may refuse such.

♣I understand that in some cases, psychotherapeutic interventions can cause anxiety and pain, and that in some cases, people who know me may not support the changes I am making.

♣I understand that my therapist may discontinue my services at any time if there is reason to believe that the interventions that are being offered are not effective. She will provide me with referrals at that time.

♣I understand that ANY threatening or bullying behaviors directed at any BCS employee or clinical participant will be grounds for immediate termination of clinical services. Suicidal and self-harm threats for the purpose of influencing the therapist fall into this category.

♣This authorization may be revoked in writing by either party at any time.

♣ I understand that although my therapist might be friendly, she is not my “friend” and that she is bound by a code of ethics to neither socialize with me outside of our sessions, nor exchange gifts with me. The clinical relationship is a professional relationship, and I am free to discuss this at any time.

I have read the above and hereby authorize my mental health treatment by Believe Counseling Services, LLC

Signature: (if printing. if uploading an electronic signature opportunity will be provided.)	Date:MM/DD/YEAR

Believe Counseling Services Intake Packet

INFORMED CONSENT PART VI: FEE ESTIMATES AND PAYMENT AGREEMENT (BCS COPY)

I,

Type full name here

("client"), hereby agree to adhere to the fees and payment terms outlined herein. All insurance rates described herein are estimates, and subject to verification by the insurance company. Insurance coverage varies and changes depending on your policy and coverage. Verification and authorizations by insurance companies do not guarantee payment or coverage. BCS reserves the right to adjust any fees or payment terms at their sole discretion. Fee/Payment Terms Policy changes will be communicated to you; written notice will be provided whenever possible; notification may be posted on the BCS Website; and verbal communication will be grounds for enforcement. Payment is due prior to each session, and to enforce this policy, this payment agreement will serve as your written authorization for BCS to charge your debit or credit card.

We bill in-network insurance companies for you. If we are out of network with your insurance company, we will provide paperwork so you can submit for reimbursement yourself.•	
Fee Schedule:	
Click here to enter initials	$175.00 for the initial (75-85minute) Intake Assessment. If we are in-network, you pay your co-pay as determined by your insurance carrier.
Click here to enter initials	$175.00 for an (45-55 Minute) Individual Therapy Session. If we are in-network, you pay your co-pay as determined by your insurance carrier.
Click here to enter initials	$50.00 per group therapy session. If we are in-network, you pay your co-pay as determined by your insurance carrier. If your insurance does not allow for group therapy sessions, you are responsible for the cost.
Click here to enter initials	$50.00 for No-Shows and Late Cancellations, both for Individual Session and for Group Sessions. (Anything less than a 24-hour notice of cancellation is considered a Late Cancellation.) You will be billed for no-shows and late cancellations. You will be responsible for paying these fees; your insurance company does not pay them.
Click here to enter initials	A limited number of people are seen on a sliding scale basis, based on income and need.
Click here to enter initials	$2.50 per day for late fees assessed, beginning 30 days from date of last service, until such time where the account is assigned to an outside collection agency, where a 30% collection fee over the new balance will be assessed. If your account becomes past due we prefer that you communicate with us so that we can arrange payment terms for you and avoid the collections process.
Click here to enter initials.	•$160.00 per hour for any services we provide that are not listed above, such as writing letters, drive time and court appearances, and reading emails.
Click here to enter initials	Clients are held responsible for late charges and collection costs, and our collection agency does report bad debt. Services may be put on hold if payments are past due.

I hereby certify that I have read and understand this Payment Agreement, and that I will adhere to the terms of this agreement.

I understand that ultimately, payment for all fees incurred by me become my responsibility.

Signature: (if printing. if uploading an electronic signature opportunity will be provided.)	Date:MM/DD/YEAR

Believe Counseling Services Intake Packet

INFORMED CONSENT PART I: NOTICE OF PRIVACY PRACTICES (CLIENT COPY)

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. If you have any questions, please ask.
Believe Counseling Services, LLC provides health care to our clients in partnership with other professionals and health care organizations. The information privacy practices in this notice will be followed by our workforce and Business Associates.

Our pledge to you:
We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements.

This notice applies to all of the records of your care generated by any of our workforce and cooperating facilities. We are required by law to keep medical information about you private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you: We may share your health information for coordination of care, treatment, payment, and healthcare operations purposes. We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to a specialist as part of a referral) (this includes psychiatric or HIV information if needed for purpose of your diagnosis and treatment): to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our healthcare operations (such as comparing patient data to improve treatment methods or for professional education purposes) (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization.) If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures other than emergencies.

Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you. We may also contact you to support our fundraising efforts. We may use or disclose medical information about you without your prior authorization for several other reasons.

Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in special circumstances, or in response to valid judicial or administrative orders or other legal purposes.

We may also disclose information about you when you are considered to be dangerous to yourself or other persons. Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections. We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

We encrypt our computer equipment and email delivery systems. We do not encrypt cell phone data, and we may transmit and/or receive information with you via our cell phones. Other uses of Medical Information:

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and/or Amend your Records: In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision. If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record. Right to an Accounting: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions. To request this list of disclosures, indicate the relevant period, which must be after April 14, 2003, but in no event for more than the last six years. You must submit your request in writing to us. Right to Request Restrictions: You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request.

Requests for Confidential Communications: You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you. Right to request a paper copy of this Notice: You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice: We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice on our Website at www. http://believeinyourtruth.com. You can receive a copy of the current notice at any time. The effective date is listed at the end of this Notice. Copies of current notices will be available each time you come here for treatment. You may be asked to acknowledge in writing your receipt of this notice.

Complaints: If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your records, let us know in writing. If you are not satisfied with our response, you may send a written complaint to the US Department of Health and Human Services Office of Civil Rights. We can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Theresa L De Armond, LPC, NCC
Believe Counseling Services, LLC

INFORMED CONSENT PART II: TPO: TREATMENT PAYMENT OPERATIONS (CLIENT COPY)

This health care facility will use your health care information for the following reasons:

TREATMENT: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case. (Note: If you are a Magellan of Arizona Recipient, we will share a minimum of your treatment plan, your ISP, and provide Monthly Updates of Progress and Concerns to your Treatment Team to ensure Coordination of Care as required by Arizona Statute.) (Note: If you were referred to us by another Clinical Professional, we will share Treatment Information with that Professional.)

PAYMENT: We may need to use or disclose information in our health record to obtain reimbursement from you, from your health insurance carrier, or from another insurer for the services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purposes of reimbursement. This information may also be used for billing, claims management, collection purposes, and related healthcare data processing through our system.

OPERATIONS:
Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and/or auditing functions.

INFORMED CONSENT PART III: MENTAL HEALTH RIGHTS GUIDELINE ONLY--(CLIENT COPY)
Some of the insurance companies provide their own Rights Handout. Feel free to ask me for yours. This is simply a summary of some of the rights and Resources for Persons with a Serious Mental Illness as outlined by law. If you are not classified "SMI" by Arizona Statute, this law does not apply to you. However, we use this law as a general guideline for operations and policy

If you are classified as "SMI" by Arizona Statute, you have legal rights under federal and state law. Some of these rights include:
•The right to appropriate mental health services based on your individual needs;
•The right to participate in all phases of your mental health treatment;
•The right to consent to or refuse treatment (except in an emergency or by court order);
•The right to treatment in the least restrictive setting;
•The right to freedom from unnecessary seclusion or restraint;
•The right not to be physically, sexually, or verbally abused;
•The right to privacy (mail, visits, telephone conversations);
•The right to file an appeal or grievance when you disagree with the services you receive or your rights are violated;
•The right to choose a designated representative(s) to assist you
•The right to a written treatment plan that sets forth the services you will receive;
•The right to associate with others;
•The right to confidentiality of your psychiatric records;
•The right to obtain copies of your own psychiatric records (unless having them wouldn't be in your best interests);
•The right to appeal a court-ordered involuntary commitment and to consult with an attorney and to request judicial review of court-ordered commitment every 60 days;
•The right not to be discriminated against in employment or housing.

If you would like information about your rights, you may call the Arizona Department of Health Services, Office of Human Rights at 1-800-421-2124. And request a copy of ADHS/BHS Form MH-211 (9/93)•Arizona Department of Health Services is responsible for administering the law 602-364-4585•ADHS Office of Human Rights will provide you an advocate should you need one 602-364-4579•Magellan is the Regional Behavioral Health Authority through whom you can file complaints/grievances 800-564-5465•Arizona Center for Disability Law is a nonprofit organization who can often help 602-274-6287

Note: If you are dissatisfied for any reason with Believe Counseling Services, LLC, or dissatisfied with any employee of BCS, please let Theresa De Armond know of your concerns, even if your concerns are about her. We are committed to the people we serve, and your feedback will help us be more effective to meet your needs, as well as the needs of others. Our phone number is 602-574-6544.You can also send an email to Theresa@believeinyourtruth.com

Thank you.

Theresa L De Armond, LPC, NCC
Believe Counseling Services, LLC

INFORMED CONSENT PART IV: MACRO COMMUNITY (CLIENT COPY)

Psychotherapy is a collaborative relationship that works, in part, because of clearly defined rights and responsibilities held by both client and therapist. It is important to know, before commencing with psychotherapy, what your rights and responsibilities are as a consumer, as well as what my rights and responsibilities are as a provider. It is also important to know what kind of situations may limit these rights and responsibilities. The following is designed to educate you about macro-community boundary issues.
BCS personnel operate from a point of reference of informed consent. Therefore we are informing you; that you may share macro-community interests with BCS, which will be discussed fully with you. If you have any questions regarding this Informed Consent Discussion, please contact our Company Offices at 602-574-6544. It is our goal to help you understand policy and ethical considerations within macro-communities.

Non-Professional relationships are inherent within macro-community settings. Counseling these settings creates challenges to maintaining client confidentiality. Confidentiality can be described as the regulation, both legal and ethical, that protect clients' rights to privacy. Privacy refers to the degree of control a client has over what happens to information about him/her held by the Professional. "BOUNDARY-CROSSING" refers to the unavoidable mix of professional and personal relationships in which the anonymity of clients and workers is compromised. "BOUNDARY VIOLATION" refers to the avoidable and/or intentional manipulation, exploitation, coerciveness and deception. Macro-communities include ties with ample opportunity for chance encounters and boundary-crossings with clients. Essentially, macro-community counselors are never off duty within these communities, which causes professional and personal relationships to overlap. Expectations for membership in a macro-community include the existence of close-knit bonds, the engagement of cultural mores and community events, consistent participation in the community, and support of relationship-building activities. The macro-community Professional is responsible for maintaining appropriate boundaries regarding confidentiality and the protection of client-related information.

INFORMED CONSENT PART IV: MACRO COMMUNITY (CLIENT COPY) con't

Type	Definition	Examples
Business Transactions	client-owned or client-employed businesses	grocery store, gas station, bank, farm implement store, telephone and electrical companies
Community committees or clubs	worker-client joint affiliation and memberships	Parent Teacher Association (PTA), Gardening and Quilting Clubs, 4-H, Rotary Club, Special Interest Groups, and Non-Profit Organizations
Community events	community-wide participatory activities	fund raisers, parades, celebrations, dances, and dinners
Social events	activity attendance that supports community members	athletic events, weddings, anniversaries, funerals, sporting events, hunting and fishing activities
Residence location	geographical proximity between client and worker	same neighborhood
Organizational location	attendance at the same organizations	schools, hospitals, and places of worship
Social and friendship networks	mutual worker-client social networks	spouses/partners, children, relatives, and friends
Incidental occurrences	addressing each other in public places	greetings on the sidewalk

I understand the possibility for potential Boundary-Crossing is increased between me and a BCS staff member within a particular macro-community. We have discussed this possibility and developed a plan. Given this information, I hereby agree to participate in psychotherapeutic services at Believe Counseling Services.