INTEGRATED MENTAL HEALTH ASSOCIATES

John Santacrose, LCSW
8079 N. 85th Way
Scottsdale, AZ 85258
480-261-5015

Client Name: _____

May I call you at:

Home: _____ Y N Work: _____ Y N
Cell: _____ Y N E-mail: _____ Y N

Address:

_____

City State Zip

Appointment Reminder Preference (circle one) Email Phone Text

Social Security No: _____ Age: _____ Date of Birth: _____

In case of emergency notify: _____

Relationship to you: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referred by: _____

If you would like us to bill your insurance company, we need the following information:

Insurance name: _____ Phone number: _____

Insured's name: _____ Relationship to you: _____

Insured's address: _____

Insured's date of birth: _____ Insured's Social Security No: _____

Member ID: _____ Group ID: _____

Effective date of coverage: _____ Deductible: _____ Ded. Amount met: _____

Copay/Coinsurance: _____

Out-of-pocket max: _____ Out-of-pocket max met: _____

Authorization required: Y N *If YES, authorization number: _____

Credit Card Authorization Form

We understand that things happen and sometimes you can't appear for your scheduled appointment. In that case, please speak with our front desk and provide 24 hour notice. Our providers set aside valuable time just for you and we often maintain a wait list, which greatly helps us to see everyone who needs to be seen. In the event of a late-cancellation (less than 24 hours) or no-show, we will charge your credit card for the full cost of the missed appointment. Thank you for your understanding.

CARDHOLDER INFORMATION

Name:_____

Billing Street Address:_____

City:_____ State:_____ Postal Code:_____

Country:_____

Direct Telephone: (_____)_____-_____

_____ **(Initials)** I authorize a $2 card fee for all credit and debit card transactions.

_____ **(Initials)** I authorize a late-cancellation charge of $75, in the event that I cancel with less than 24 hour notice, against my credit card.

_____ **(Initials)** I authorize a no-show charge of $75, in the event that I do not appear for my scheduled appointment, and I do not call (no emails, please) to cancel against my credit card.

If you need to cancel or reschedule an appointment, please call our office at 480-261-5015, extension 0, (no e-mails, please).

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number:_____

Expiration Month:_____ Expiration Year:_____

Cardholder Signature X_____ Date___/___/____

Security Code:_____

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CLIENT INFORMATION

The information you provide to the following may help me understand your situation. Please be aware that this *Info* will be kept in your *Record* which may be accessed by your insurance carrier. If there is any *Info* you want me to have but are uncomfortable entering it into your *Record*, leave those items blank. You may share it with me during our session.

PRESENTING PROBLEM(S):

Please describe your reasons for seeking services:

_____

_____

Was there an event which made these issues or problems surface? Y N

If yes, please describe:

_____

_____

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/relationship N/A	1	2	3	4	5	N/A
Family N/A	1	2	3	4	5	N/A
Job/School Performance N/A	1	2	3	4	5	N/A
Friendships N/A	1	2	3	4	5	N/A
Hobbies N/A	1	2	3	4	5	N/A
Financial Situation N/A	1	2	3	4	5	N/A
Physical Health N/A	1	2	3	4	5	N/A
Anxiety Level/Nerves N/A	1	2	3	4	5	N/A
Mood N/A	1	2	3	4	5	N/A
Sexual Functioning N/A	1	2	3	4	5	N/A
Ability to Concentrate N/A	1	2	3	4	5	N/A
Ability to Control Temper N/A	1	2	3	4	5	N/A
Spirituality N/A	1	2	3	4	5	N/A
Eating Habits N/A	1	2	3	4	5	N/A
If affected, describe how: _____						
_____						
Sleeping Habits N/A	1	2	3	4	5	N/A
If affected, describe how: _____						
_____						

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EDUCATION/CAREER

School completed?

High School _____ Vocational _____ College _____ Graduate _____

Are you currently in school or a training program? Y ☐ N ☐

If yes, where? _____ Area of study? _____

Are you currently employed? Y ☐ N ☐

Employer? _____

Job/Occupation: _____

Other jobs, last five years? _____

_____

RELATIONSHIP BACKGROUND

	Name	Age (or deceased)	Level of Education	Occupation
Spouse/ Partner				
Children				

	Yes/No	When?	What/Whom?
Have you ever been separated/divorced?			
Have you ever been in a physically or sexually hurtful or abusive relationship?			
Has your partner had a problem with alcohol or drugs?			

FAMILY BACKGROUND (include step-parents if applicable)

	Name	Age (or deceased)	Level of Education	Occupation
Father				
Mother				
Siblings				

	Yes/No	When?	Whom?
Have your parents ever been divorced?			
Have either of your parents ever had a problem with alcohol or drugs?			
Was there any physical or sexual abuse in your family?			
Are you in contact with your parents?			
Are you in contact with your siblings?			

Describe any medical or psychiatric conditions of your parents and siblings (including substance abuse):

_____

MEDICAL HISTORY

Describe your physical health (circle one): excellent good fair poor very poor very poor

What prescription/non-prescription medications/drugs do you take or use?

Name	Dose	Start Date	Side Effects?

Please list any past or present condition for which you are being or have been treated:

_____

_____

Do you have allergies? Y N If yes, please list: _____

When did you last have a physical examination? _____

Who did you see? _____

Name Phone Number

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PSYCHIATRIC HISTORY

Have you ever received **psychological or behavioral health** treatment of any kind before? Y N No

If yes, please answer the following:

What type of care did you receive? Inpatient (hospital) Outpatient Both

When were you in treatment? _____

Where were you in treatment? _____

How long were you in treatment? _____

Who was your therapist or doctor? _____

Did your doctor prescribe medicine at that time? Y ☐ N ☐

If yes, what was prescribed (include dosages if known)? _____

_____

SUBSTANCE USE HISTORY

How often do you use:

	Never	Monthly	Weekly	Daily
Alcohol				
Cocaine				
Hallucinogens (i.e. LSD)				
Inhalants (i.e. paint)				
Marijuana				
Methamphetamine				
Narcotics (i.e. heroin)				
Over-the-counter drugs				
Tobacco				
Coffee/Soda				
# of cups/cans				
Other				

Have you ever received substance abuse treatment of any kind before? ☐ Y N ☐

Have you ever felt you had a problem with, or ought to cut down on, your drinking or drug use? Y N No

Please describe anything else you would like me to know:

INTEGRATED MENTAL HEALTH ASSOCIATES

PSYCHOTHERAPY AGREEMENT

PSYCHOTHERAPY

Psychotherapy varies depending on the personalities of the therapist and patient, and the problems being addressed. Often it involves difficult aspects of life and experiencing uncomfortable feelings. *Beneficial results depend on an active effort on your part.*

I may use different methods in therapy. Generally my approach invites your close attention to, and the expression of, your internal experience including thoughts, feelings, and recollections of personal history. We will also explore your perceptions of the world around you. Together we will identify ways that you are behaving and ways that you interact with your world, both those that serve you and those that limit you or create problems.

I will invite you to explore by talking about personal material, by expressing behaviors (some apparent and some out of your awareness), and by experimenting with new behaviors. The degree to which the therapy is successful often depends on your willingness to practice what is experienced in therapy in your daily life. The intent of this therapy is to help you become a more effective participant in life.

Therapy is a unique learning experience we both create. I provide expertise in recognizing clinically important material and structuring meaningful therapeutic opportunities. You are responsible for saying what is important to you, what you have come to therapy to address, and deciding for yourself what is useful. You always have the right, in fact it is important for you, to raise your own needs and any objections or reservations you may have about what we do. *It is not my job to tell you what to do. It is your job to make your own decision about what is best for your life.*

There are times, despite the best efforts of both the client and the therapist, that the therapy is not helpful. Sometimes a particular therapist or therapeutic approach is simply not a good match. If at any time you feel your therapy with me is not satisfactory, please let me know. If we are unable to make suitable adjustments I will make every effort to locate another therapist for you.

CONFIDENTIALITY AND PERSONAL INFORMATION

The law protects the privacy of all communication between a patient and therapist and dictates how I manage your personal information. Please read the notice entitled “Your Personal Information” about the policies and limitations regarding your privacy.

APPOINTMENTS

Unless otherwise arranged, therapy sessions are scheduled for 55 minutes. Together we will agree on our frequency of meeting. Weekly or every other week are common frequencies, especially at the beginning of therapy.

A scheduled appointment means I reserve time only for you. If you miss your appointment or cancel with less than 24 hours notice, you will be billed according to the scheduled fee before another appointment can be scheduled. Generally, your insurance company does not pay this fee.

CONTACTING ME

Messages can be left for me at the office number of (480) 261-5015. Unless we have specifically made other arrangements, I do not provide on-call phone or emergency sessions. In an emergency contact 911, a hospital emergency room, or the EMPACT Crisis Hotline at (480) 784-1500. If you feel you require special support between our scheduled sessions, please discuss these needs with me.

FINANCIAL TERMS

- Unless otherwise arranged, my fee for an initial consultation is $250. The fee for subsequent appointments is $190 for individual sessions and for or other multiple participants. Services for time periods other than a usual appointment are charged proportionally at $190/hour. Examples include report writing, phone conversations beyond a few minutes, or consulting with others at your request.
- Upon verification of insurance coverage and policy limits, your insurance carrier will be billed for your sessions. I will be paid directly by the carrier and you will be responsible for any deductibles and co-payments. If your insurance plan determines you are not eligible, you are responsible for full payment at the fee schedule above.
- Payment arrangements should be finalized at your first visit.
- In the event of default of payment, the balance is due in full. You will be responsible for any reasonable court costs, attorney fees, and/or collection fees incurred.

LIMITS OF COVERAGE, APPEALS, AND GRIEVANCES

It can be difficult to determine health plan coverage. Some require authorization before they pay and may limit the number of visits. You have the right to request reconsideration if visits are denied certification. You would appeal through me and have no risk in doing so. If you continue without authorization and your appeal is denied, you will be responsible for payment of sessions not approved. You may make a complaint to me about any aspect of treatment. If not satisfied, you may submit a grievance to your insurance carrier.

CONSENT FOR TREATMENT

I authorize and request that Integrated Mental Health Associates carry out behavioral health treatment and/or diagnostic procedures which now or during the course of my care are advisable.

I acknowledge that I have been provided with a copy of this Psychotherapy Agreement and have read, understand, and agree to what is presented.

I further acknowledge that I have been provided with a copy of the notice entitled “Your Personal Information with Integrated Mental Health Associates.” I authorize the use and disclosure of my information as defined in the notice.

I acknowledge that at Integrated Mental Health Associates office space is shared but patient clinical care is separate.

I authorize payment of medical benefits to Integrated Mental Health Associates for services described.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE

_____ _____

Patient (or Parent Guardian) Signature Date Signed

INTEGRATED MENTAL HEALTH ASSOCIATES

_____
Patient (or Parent/Guardian) Printed Name

Your Personal Information with
Integrated Mental Health Associates

I. General Consent

With your signature on the Psychotherapy Agreement, you give me your general consent for treatment, which includes your permission for me to *use* or *disclose information (info)* about you for the purposes of *payment*, *treatment*, and *operations*.

Some clarifications:

Information (Info)	means information I keep that could identify you.
Treatment	means when I provide, coordinate, or manage your care. This includes activities such as consulting with your physician or another treatment professional. If I choose to consult with a colleague regarding your case, I do not reveal your identity and will note these consultations in your record.
Payment	means when I disclose your *info* to obtain reimbursement, such as to your health insurer to determine coverage or for payment.
Operations	refers to the activities of operating my practice and business-related matters. My office manager, and my accountant on very rare occasions, may have limited access to your *info*. Both have been trained about protecting your privacy.
Use	means using your *info* only within my office.
Disclose	means providing your *info* to others outside of my office.
Record	refers to the file of all the information I keep for managing your therapy except for *psychotherapy notes*. Examples include the intake paperwork, billing and insurance documents, a diagnosis, and goals for treatment.
Psychotherapy Notes	refers to notes I have made about our conversations for my own use in your treatment. I keep these notes separate from your record and under greater protection.

II. Authorization

An *authorization* is your signed, written permission which permits only specific disclosures above and beyond the general consent. When I am asked for *info* for purposes outside of *payment*, *treatment*, or *operations*, I will obtain an *authorization* before releasing this information from your *record* or from my

psychotherapy notes. You may revoke an *authorization* at any time, provided your revocation is in writing. However, you may not revoke an *authorization* to the extent that (1) I have relied on it; or (2) it was obtained as a condition for insurance coverage and law gives the insurer the right to contest the claim. Insurance companies may request *info* from your *record* but not from *psychotherapy notes* without your *authorization*.

III. Uses and Disclosures Without Consent or Authorization

I may *use* or *disclose* your *info* without your consent or *authorization* in the following circumstances:

Child Abuse. I am required to report to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.

Adult and Domestic Abuse. If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to report to authorities when I have a reasonable basis to believe that abuse or neglect has occurred or that exploitation of the adult's property has occurred.

Health Oversight Activities. If the Arizona Board of Behavioral Health Examiners is conducting an investigation, I may be required to *disclose* your *info* to them.

Judicial and Administrative Proceedings. If you are involved in a court proceeding and a request is made for records and/or information about our work together, such information is privileged under state law and I will not release it without your written *authorization,* or that of your legally appointed representative, or a court order. If a patient files a complaint or lawsuit against me, I may *disclose* relevant *info* in order to defend myself.

Serious Threat to Health or Safety. If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identifiable victim (or victims) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring. This may include *disclosing info* to the potential victim and/or to the police, and to initiate the appropriate hospitalization procedures. If I believe that there is an imminent risk that you will inflict serious harm on yourself, I may *disclose info* in order to protect you.

Worker's Compensation. I may *disclose* your *info* as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs that provide benefits for work-related injuries or illnesses.

IV. Your Rights and My Duties

Your right to request restrictions on my *uses* and *disclosures* of your *info.* However, I am not required to agree to it.

Your right to request and receive confidential *info* by alternative means and locations. For example, if you want your bill sent to another address so that a family member will not know that you're seeing me.

Your right to inspect or receive a copy of your *record* as long as I am keeping one. There are some circumstances under which I may deny this, and in some cases you may have the denial reviewed. If you'd like, I will discuss these details with you.

Your right to request to see my *psychotherapy notes.* However, I am not obligated to agree to it.

Your right to request a change to your *record* as long as I am keeping one. I may deny this request. If you'd like, I will discuss these details with you.

Your right to receive documentation of *disclosures* of your *info*. If you'd like, I will discuss these details with you.

Your right to receive paper copies of this notice and of any of our agreements.

Your right to fully discuss with me any questions or concerns you have regarding confidentiality and your personal information.

My duty by law to maintain the privacy of your *info* and to provide this notice of my policies and procedures for doing so.

My duty to abide by these terms regarding your *info*. I do have the right to change privacy policies if I notify you.

My duty that if I revise my *info* policies and procedures, to provide you a revised notice. I will do this at one of our regular appointments or by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with my decision about access to your *record*, please let me know. If you feel unsatisfied with our resolution or want further input you may contact the Arizona Board of Behavioral Health Examiners. I can provide you with the contact information upon request.

VI. Minors and Parents

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

VII. Minimum Necessary Requirement

Under circumstances of *disclosure* of your *info* I will make every effort to release only the minimum *info* about you that is necessary for the requested purpose. Be aware that your contract with your health insurance company requires that I provide it with *info* about you, including a clinical diagnosis. Sometimes I am required to provide treatment plans, summaries, or the entire *record.* This *info* will become part of the insurance company's files. Although they claim to keep it confidential, I have no control over your information once they have it. I will provide you with a copy of any report I submit if you request it. Your insurance company cannot require access to my *psychotherapy notes* as a condition of coverage.

VIII. Record Storage, Access, and Disposition

While you are an active client, your *record* and my *psychotherapy notes* are kept in locked storage at my office. Once you are inactive as a client these records are transferred to a secure storage site separate from my office. The records will be maintained and securely stored for seven years from the date of and last activity as a client. After seven years, your *record* and my *psychotherapy notes* will be destroyed using a commercial shredding company licensed to properly handle secure confidential records.

If you wish to access your *record* or you require information from your *record*, contact us. If you do not know how to find me, information for contacting me or an alternate Custodian of Records is on file with the Arizona Board of Behavioral Health Examiners, 3443 North Central, Suite 1700, Phoenix, AZ 85012; phone (602) 542-1882.

IX. Effective Date

This notice was revised and is in effect as of September, 2018.

Confidentiality

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) Suspected abuse or neglect of a child, elderly person or a disabled person, 2) When your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3) If you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4) If your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc., 5) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6) In natural disasters whereby protected records may become exposed or 7) When otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals or family members.

_____ _____

Patient (or Parent Guardian) Signature Date

_____

Patient (or Parent Guardian) Printed Name