INTEGRATED MENTAL HEALTH ASSOCIATES

Erica Tatum-Sheade, 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 missed appointment fee. 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 (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:_____

INTEGRATED MENTAL HEALTH ASSOCIATES

Erica Tatum-Sheade, LCSW

Child's Name: _____ Date: _____

Child's age: _____ Date of Birth: ____ / ____ / _____ Sex (circle one): Male Female

Address: _____

Street _____ _____ _____

City State Zip

Phone: (Home) _____ (Cell) _____

Person filling out form:_____

Name of person responsible for bill:_____

Emergency Contact: _____ Relationship _____ Phone _____

Parents / Stepparents

Mother's name: _____ Age: _____ Education: _____

Occupation: _____

Father's name: _____ Age: _____ Education: _____

Occupation: _____

Marital status of parents: _____

If parents are separated/divorced, how old was child at time of separation? _____

Stepparent's name: _____ Age: _____ Education: _____

Occupation: _____

Stepparent's name: _____ Age: _____ Education: _____

Occupation: _____

With whom does the child live? _____

Custody (circle one):

Lives in one home with both legal parents ☐ Father has physical custody ☐

Mother has physical custody ☐ Physical custody is shared ☐

Other: _____

List all people living in household: Name Age Relationship to child

_____
_____
_____
_____

If any brothers or sisters are living outside the home, list their names and ages:

_____
_____

If any brothers / sisters are deceased, please give name and year: _____
_____

FAMILY INFORMATION:

Place of birth: _____

Child's Race (circle which applies):

African-American ☐ **Caucasian** ☐ **Native American** ☐ **Hispanic** ☐ **Asian** ☐ **Latino** ☐

Other (specify) _____

Was the child adopted? **Yes**____ **No**____ If yes, at what age? _____ From where? _____

Has the child ever been placed outside of the home? **Yes**☐ **No**☐ If yes, where? _____

In how many residences has the child lived since birth? _____

Has the child been physically or sexually abused, assaulted or molested? **Yes**☐ **No**☐ **Don't know**☐

If yes, specify by whom and when:

_____

Have the child's parents or any other family members had any mental health or emotional problems?
Yes☐ **No**☐

If yes, describe: _____
_____
_____

PRESENTING PROBLEM: Briefly describe your child's current difficulties:

_____
_____
_____
_____
_____
_____

How long has this problem been of concern to you?

_____

When was the problem first noticed?

_____

What seems to help the problem? _____
What seems to make the problem worse?_____

Has the child received evaluation or treatment for the current problem or similar problems? **Yes** ☐ **No** ☐

If yes, when and with whom? _____

Is the child on any medication at this time? **Yes ____ No ____**

If yes, please note kind of medication: _____

_____

How do you want your child's situation to be different after coming here?

_____
_____
_____
_____

SOCIAL AND BEHAVIOR CHECKLIST: Place a check next to any behavior or problem that your child currently exhibits.

____ Has difficulty with speech

____ Has frequent tantrums

____ Has difficulty with hearing

____ Has frequent nightmares

____ Has difficulty with language

____ Is more interested in things (objects) than in people

____ Does not get along well with other children

____ Is aggressive

____ Is shy or timid

____ Has poor bowel control (soils self)

____ Has difficulty with vision

____ Has blank staring spells

____ Has difficulty with coordination

____ Rocks back and forth

____ Prefers to be alone

____ Bangs head

____ Holds breath

____ Eats poorly

____ Is stubborn

____ Is much too active

_____Has trouble sleeping (describe) _____

Engages in behavior that could be dangerous to self (describe)

_____

Describe child's relationship with his / her:

Father _____
Mother_____
Sibling(s)_____
Step parent(s) _____

OTHER INTERPERSONAL RELATIONSHIPS:

How do you describe the child's friendships (Circle one):

☐ **No Friends** ☐ **Only Acquaintances** **Both acquaintances and close friends** ☐

How many close friends? _____

Place a check next to any behavior or problem that your child currently exhibits.

_____ Has special fears, habits, or mannerisms

_____ Is impulsive (describe) _____

_____ Shows daredevil behavior

_____ Sucks thumb

_____ Gives up easily

_____ Is slow to learn

_____ Wets bed

_____ Other (describe):

_____
_____

EDUCATIONAL HISTORY

School: _____ Grade: _____

Place a check next to any educational problem that your child currently exhibits: Check

_____Has difficulty with reading _____Has difficulty with math

_____Has difficulty with spelling _____Has difficulty with writing

_____Has difficulty with other subjects (please list_____)

_____Does not like school

Is your child in a special education class? Yes _____ No _____

If yes, what type of class? _____

Has your child been held back in a grade? Yes _____ No _____
If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? Yes _____ No _____
If yes, please describe: _____

Has your child ever been suspended or expelled? Yes _____ No _____
If yes, please describe: _____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes ____ No ____ If yes, what kind? _____

During pregnancy, did mother smoke? Yes ____ No ____ If yes, how many cigarettes each day? ____

During pregnancy, did mother drink alcoholic beverages? Yes ____ No ____
If yes, what did she drink?_____

Approximately how much alcohol was consumed each day?_____

During pregnancy, did mother use drugs? Yes ____ No ____ If yes, what kind? _____

Were forceps used during delivery? Yes ____ No ____

Was a Cesarean section performed? Yes ____ No ____ If yes, for what reason? _____

Was the child premature? Yes ____ No ____ If so, by how many months? _____

What was the child's birth weight? _____

Were there any birth defects or complications? Yes ____ No ____
If yes, please describe: _____

Were there any feeding problems? Yes ____ No ____

If yes, please describe: _____

Were there any sleeping problems? Yes ____ No ____

If yes, please describe: _____

As an infant, was the child quiet? Yes ____ No ____

As an infant, did the child like to be held? Yes ____ No ____

Were there any special problems in the growth and development of the child during the first few years?
Yes ____ No ____
If yes, please describe: _____
_____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Showed response to parent _____

Rolled over _____

Sat alone _____

Crawled _____

Walked alone _____

Babbled _____

Spoke first word _____

Put several words together _____

Dressed self _____

Became toilet trained _____

Stayed dry at night _____

Fed self _____

Rode tricycle _____

CURRENT HEALTH INFORMATION:

Describe child's health generally: ☐ **Good** ☐ **Fair** ☐ **Poor**

Is the child sexually active? ☐ **No** ☐ **Yes**

List any health problems the child has had _____

_____

_____

Does the child have: Current immunizations ☐ **No** ☐ **Yes**

Which are needed? _____

Any allergies ☐ **No** ☐ **Yes** Specify _____

Nutritional problems ☐ **No** ☐ **Yes** Specify _____

Appetite problems ☐ **No** ☐ **Yes** Specify _____

Sleep problems ☐ **No** ☐ **Yes** Specify _____

A disability or handicap ☐ **No** ☐ **Yes** Specify _____

Contagious or other diseases ☐ **No** ☐ **Yes** Specify _____

Any accidents / injuries ☐ **No** ☐ **Yes** Specify _____

Dental, vision or hearing problems ☐ **No** ☐ Yes Specify _____

Any hospitalizations ☐ **No** ☐ **Yes** Specify _____

Physician: _____

Date of last contact: ____ / ____ / ____ Reason for last contact: _____

SUBSTANCE USE / ABUSE:

Please complete the chart below

Category of Drug	Has the child used?	Currently using?	How often?	Age of first use?	How often does child use?	How taken?	Use last 48 hours	Withdrawal symptoms
Alcohol								
Stimulant								
Cocaine								
Tranquilizer								
Barbiturates								
Marijuana								
Opioids								
Hallucinogen								
Prescribed								
Nicotine								
Caffeine								
Other								

FAMILY MEDICAL HISTORY: Place a check next to any illness or condition that any member of the child's family has had. When you check an item, please note the member's relationship to the child. Check Condition Relationship to child Check Condition Relationship to child

_____ Alcoholism _____

_____ Cancer _____

_____ Diabetes _____

_____ Heart trouble _____

_____ Bipolar Disorder _____

_____ Other _____

_____ Depression _____

_____ Learning disability _____

_____ ADHD _____

_____ Mental Retardation _____

_____ Anxiety Disorder _____

LEGAL INFORMATION:

Has the child ever:

Had difficulty or contact with police? ☐ Yes ☐ No

Appeared in juvenile conference? ☐ Yes ☐ No

Been on probation? ☐ Yes ☐ No

Please explain: _____

OTHER INFORMATION:

What are your child's favorite activities?

1. _____

2. _____

3. _____

What activities would your child like to engage in more often than he/she does at present?

1. _____ 2. _____

What activities does your child like least?

1. _____ 2. _____

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other

_____ Ignore problem behavior

_____ Scold child

_____ Spank child

_____ Threaten child

_____ Redirect child's interest

_____ Tell child to sit on chair

_____ Send child to his or her room

_____ Take away some activity

_____ Reason with child

_____ Don't use any technique

_____Other technique (describe) _____

_____

Which disciplinary techniques are usually effective?

_____

_____

With what type of problem(s)? _____

_____

_____

Which disciplinary techniques are usually ineffective? _____

_____

_____

With what type of problem(s)?

_____

_____

What have you found to be the most satisfactory ways of helping your child? _____
_____
_____

What are your child's assets or strengths? _____
_____
_____
_____

PREVIOUS COUNSELING / PSYCHOTHERAPY:

Has your child ever been in counseling / therapy before? ☐ No ☐ Yes

Name of Provider Clinic Year Diagnosis / Problem/Reason For Stopping

_____
_____
_____

Has your child been prescribed psychotropic medication? ☐ No ☐ Yes

Medication: _____ Dosage: _____

Prescribed by: _____

Medication: _____ Dosage: _____

Prescribed by: _____

Reason:

_____

Other medications currently prescribed:

Medication: _____ Dosage: _____ Prescribed by: _____
Medication: _____ Dosage: _____ Prescribed by: _____
Medication: _____ Dosage: _____ Prescribed by: _____
Reason: _____

Has the child ever: Made a suicide attempt: ☐ No ☐ Yes

If yes, when? _____

Expressed homicidal thoughts: ☐ No ☐ Yes

Describe _____

Had episodes of explosive anger: ☐ No ☐ Yes

Describe _____

Is the child currently expressing homicidal / suicidal feelings? ☐ No ☐ Yes

Describe _____

Any other information you would like me to know

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Informant _____Date _____

Relationship to client _____

Signature of Client _____Date _____

Signature of Therapist _____Date _____

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 50 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 you are responsible for this payment. Excessive no shows and late cancellations will result in a cancellations of any reoccurring scheduled appointments.

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 Crisis Hotline at 602-222-9444 If you feel you require special support between our scheduled sessions, please discuss these needs with me.

FINANCIAL TERMS

- Unless otherwise arranged, my fee is $225 for individual sessions and for other multiple participants, 30min parent consultations are billed at $95 (these are not covered by most insurance companies). Services for time periods other than a usual appointment are charged proportionally at $225/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.

SOCIAL MEDIA POLICY

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy

Friending -I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Interacting- Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact me between sessions, the best way to do so is by directly calling the front desk at 480-261-5015 or email me directly for quick, administrative issues such as changing appointment times.

NON-RECORDING AGREEMENT

Successful therapy depends on building a relationship of trust, good faith, and openness between client(s) and therapist(s). Often, audio or video recording can inhibit candor and introspection in therapy. Covert recording is a direct violation of trust and good faith to all the other persons in the room. In addition, recordings made and taken home by clients sometimes fall into unintended hands through loss, random or targeted theft, or action by police, court or governmental agency. Such loss could compromise or nullify your legal expectation of confidentiality in the extremely sensitive personal or interpersonal matters that may have been discussed. Courts may not give your own recordings all the legal confidentiality they give to a therapist's office notes and may find them self serving. Client recordings can more easily end up becoming an issue in conflicts such as divorce, child custody, or other legal cases or be used by agencies of government. A client who makes a recording solely for personal use or to use against a partner may later be surprised to find the recording being used against him- or herself instead. And once an unfavorable recording exists, its deletion can become legally punishable if a subpoena is issued for it. Factors like these undermine the therapeutic process and the building or rebuilding of trust that takes place between partners in session and between the client(s) and therapist(s). For these reasons and others like them, Integrated Mental Health Associates maintains a strict policy *against* the recording of sessions.

PARTICIPATION IN LITIIGATION:

I will not voluntarily participate in any litigation, or custody dispute in which client and another individual, or entity, are parties. I have a policy of not communicating with client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in a legal matter unless agreed upon at beginning of the therapeutic relationship. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, client agrees to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate of $225/hour.

VIRTUAL TELEHEALTH / TELETHERAPY:

The confidentiality of all communications between a client and a therapist is generally protected by law and as your therapists cannot and will not tell anyone else what you have discussed or even that you are in counseling services without your written permission, This is also true with virtual telehealth/teletherapy sessions. Limits of confidentiality are the same as listed under our CONFIDENTIALITY section. For Teletherapy services, we offer a HIPAA compliant platform for virtual therapy video conferencing therapy via Simple Practice. We offer the same quality of care with our virtual online therapy services as in our in person sessions. For virtual sessions client agrees to the following

- Hold the session in a room that is appropriate for a web-based session, such as a home office
- Do not have anyone else in the room unless you first discuss it prior to your appointment.
- Not conduct other activities while in session, such as driving
- Do not record sessions without first obtaining approval
- Be located within the state of Arizona where I am licensed to practice (unless previously discussed with counselor)
- Minors should have a parent or guardian with them at the location/building of the web-based session, unless otherwise agreed upon.

Limitations of Telehealth:

Telehealth should not be viewed as a substitute for face-to-face sessions. It is an alternative form of therapy with certain limitations. By signing this document, you agree that you understand that Telehealth:

- May lack of visual and/or audio cues, which may cause misunderstanding. Whenever there is communication that lacks visual or audio cues there is a risk of misunderstanding. When this happens, it is important to assume that your counselor has positive regard for you, and to check out your assumptions. This will reduce any unnecessary hardship.
- May have disruptions in the service and quality of the technology used.
- May not be appropriate if you are having a crisis, acute psychosis, or suicidal or homicidal thoughts.

ADOLESCENT CONSENT AND PARENT AGREEMENT TO RESPECT PRIVACY

What to expect:

The purpose of meeting with a therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling. *As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information.* There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

> You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.

>You are doing things that could cause serious harm to you or someone else, even if you do not *intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Arizona Department of Economic Security.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission

and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

* * * * *

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____ Date_____

Parent Agreement to Respect Privacy

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your adolescent's privacy:

-____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

___ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Therapist Signature _____ Date_____

CONSENT FOR TREATMENT

I authorize and request that Erica Tatum-Sheade, LCSW 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 Erica Tatum-Sheade, LCSW." I authorize the use and disclosure of my information as defined in the notice.

I acknowledge that Erica Tatum-Sheade, LCSW is a sole practitioner and not in a group practice. Office space is shared but patient clinical care is separate.

I authorize payment of medical benefits to Erica Tatum-Sheade, LCSW for services described.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE

_____ _____

Patient (or Parent Guardian) Signature Date Signed

_____

Patient (or Parent/Guardian) Printed Name

Erica J Tatum-Sheade, LCSW

Safe Harbor Agreement

1. Parties. The Parties to this Agreement are _____and _____ (together "the parents)

and _____(the therapist)

2. Goal. The therapeutic goal is to permit the children to have a place that they deem safe to be able to speak to a mental health provider about any apprehensions, concerns, or issues without feat that what they say will be used to interfere with, or create problems with either parent

3. Safe Harbor. In order to effectuate the stated goal, the parties acknowledge the importance of the therapists office being a safe harbor-a place where the children can be truthfully assured that what they say will not be disclosed to third parties without their consent.

4. AGREEMENT. Therefore, to create the safe harbor for the children parties agree as follows

    a. No court/no depositions. Neither parent shall, nor will either parent permit his or her attorney to, subpoena the therapist or her notes to a trial, hearing. Deposition, or arbitration

    b. No interrogations. Neither parent shall, nor will either parent permit his or her attorney to, demand answers from either the therapist or the children to questions about the content of the therapy
    c. No disclosure. The therapist agrees that she shall not divulge to either parent, to either attorney, to the judge or to any other third party, any matter relating to the content of the therapy with the children (except required disclosures under the Child Abuse

Reporting Act, or other safety concerns) without the children's explicit consent

d. Enforcement. Any party, or his or her attorney, who seeks to interrogate or subpoena the therapist shall be liable for all attorney fees and costs incurred to resist answering discovery request or to quash a subpoena

Parent	Date
Parent	Date
Therapist	Date

INTEGRATED MENTAL HEALTH ASSOCIATES

Your Personal Information with
Erica Tatum-Sheade, LCSW

Please read this notice describing how I handle information about you in compliance with state and federal law, and describing your access to this information.

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 me, Erica Tatum-Sheade, LCSW. 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 August 2020.