Dr. Chelsie Reed, pllc
PhD Psychology, LPC
3115 S. Price Rd.
Chandler AZ, 85248
Phone: (480) 855-4009
Fax: (480) 855-2303

New Client Information

Referred By: _____ **Today's Date:** _____

I. Client Information

Name: _____ Social Security #: _____

Birth Date: _____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

In case of emergency, please notify:

Name: _____ Phone: _____ Relationship: _____

Please complete this section for others residing in the client's primary residence.

Name	Birth Date	Age	Relationship to Client	Gender

III. Client Occupational/Educational Status

Currently employed? ☐Yes ☐No If yes, Occupation: _____ Company: _____

If you're not employed, please check any of the following: ☐Retired ☐Unemployed ☐Disability ☐Student

IV. Client Background Information

The following information is optional but will help me to better serve you.

Ethnicity
- ☐ American Indian / Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ African-American/Black
- ☐ Hispanic/Latino
- ☐ Caucasian/White
- ☐ Bi-Racial
- ☐ Multi-Racial
- ☐ Other: _____

Highest Level of Education
- ☐ Elementary School: Grade ___
- ☐ Some High School
- ☐ High School Diploma
- ☐ Some College/Technical School
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctoral Degree

Marital Status
- ☐ Single
- ☐ Living Together/Not Married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Sexual Orientation
- ☐ Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ Transgendered
- ☐ Not sure/questioning

V. Client's Mental Health History

Have you had prior mental health related services? YES _____ NO _____

Prior Therapy & Hospitalizations for Mental Health (name of clinician, reason and outcomes):

_____

_____

_____

VI. Client's Health Status

Current or chronic medical issues: _____

Primary Care Doctor: _____ Phone: _____

May I contact your Primary Care Doctor to coordinate care? Yes _____ No _____

VII. Client's Medication History

Have you **previously** taken medications for emotional/substance abuse problems? YES _____ NO _____

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:
Dates Used:	Dates Used:	Dates Used:

Are you **currently** taking any medications for emotional/substance abuse problems? YES _____ NO _____

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:
Dates Used:	Dates Used:	Dates Used:

Other medications and vitamins: _____

_____

_____

_____

Prescribing Physician: _____ Phone: _____

VIII. Problem Category (please check all that apply):

☐ Emotional Health	☐ Family issues	☐ Work-related	☐ Financial
☐ Substance use/abuse	☐ Eating disorder	☐ Children	☐ Legal
☐ Suicide Risk	☐ Abuse/violence	☐ Health-related	☐ Other:
☐ Marital/Relationship Issues	☐ Court ordered		_____

Please briefly describe why you are choosing to enter treatment at this time:

_____

_____

_____

_____

_____

PLEASE COMPLETE THE FOLLOWING IF CLIENT IS A MINOR

IX. Family Information

The Minor's Biological Parents Are:		**How is Custody Arranged?**
☐ Never Married/Never Together	☐ Separated	☐ Sole
☐ Living Together/Not Married	☐ Divorced	☐ Joint
☐ Married	☐ Widowed	☐ Guardian Appointed

Biological Mother Name: _____ DOB: _____ Age: _____ Occupation: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Telephone - Home: _____ Work: _____ Cell: _____

Biological Father Name: _____ DOB: _____ Age: _____ Occupation: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Telephone - Home: _____ Work: _____ Cell: _____

Stepmother/Guardian Name: _____ DOB: _____ Age: _____ Occupation: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Telephone - Home: _____ Work: _____ Cell: _____
If guardian, relationship to child: _____

Stepfather/Guardian Name: _____ DOB: _____ Age: _____ Occupation: _____
Street Address: _____ City: _____ State: ____ Zip: _____
Telephone - Home: _____ Work: _____ Cell: _____
If guardian, relationship to child: _____

Information About Other Children in the Family:

Name	**Age**	**Relationship to Client Full/Step/Half**	**Gender**	**Living With**

OUTPATIENT SERVICES CONTRACT

Welcome. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient/client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (Arizona Notice Form) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time, When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. Please note that Dr. Chelsie Reed, PLLC is not a part of a group practice and as such not responsible for any actions, negligence, or other behavior by any party with whom share office space, conference, or other event.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient/client, as well as the particular problems you discuss. There are many different methods that I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. **Instead, it requires a very active effort on your part.** In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness. guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you may experience.

The first 2 to 3 sessions will involve an evaluation of your needs and may include some formal psychological testing. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. By the end of the evaluation, you will be offered some first impressions of what our work will include and a treatment plan will be developed, if you decide to continue with therapy. You are strongly encouraged to evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so it is recommended that you be thoughtful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional for a second opinion. Should you not engage in treatment for longer than 60 days without an agreed upon therapy break, your file will be closed and you will no longer be considered an active client of Dr. Chelsie Reed, PLLC.

PROFESSIONAL FEES

The initial consultation is $150. Any subsequent appointments are $150/therapy hour. I will usually schedule one appointment hour of 50 minutes duration per week, at a time that we agree on, although some sessions may be longer or more or less frequent. In addition to weekly appointments, I charge $150 per hour for other professional services you may need including: report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service that you may request of me. If you become involved in legal proceedings that require my participation (see provisions for serving as a treating clinician), you will be expected to pay for my professional time, including preparation and transportation costs. Because of the complexity of legal involvement, I charge $275 per hour with a four-hour minimum requirement for preparation, travel time, and attendance at any legal proceeding. In addition this fee will need to be paid in advance.

Client/Parent or Guardian Initial _____ Spouse/Other Parent or Guardian Initial _____

BILLING AND PAYMENTS

You are expected to pay for each session at the time it is held, no insurance billing will be done by the offices of Dr. Chelsie Reed. I am happy to assist in information to you to allow you to bill out-of-network benefits if you choose and if you have those benefits. Thus**, it is very important that you find out exactly what mental health services your insurance policy covers.** You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and I will be happy to help you in understanding the information you receive from your insurance company. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you should you use your out-of-network benefits. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier. Though, overall **you (not your insurance company)** are responsible for full payment of my fees. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

Client/Parent or Guardian Initial _____ Spouse/Other Parent or Guardian Initial _____

I require a **48 hour** advanced notice for any cancellation of a scheduled appointment. It is possible to call and leave a message 24 hrs a day. You will be charged **$50** for any cancellation made with less than **48-hours notice, and $75 for any no show**. Late cancellations will be charged directly to you and not the insurance company.

Client/Parent or Guardian Initial _____ Spouse/Other Parent or Guardian Initial _____

If your account has not been paid for more than **45 days** and arrangements for payment have not been agreed upon. Dr. Chelsie Reed, PLLC reserves the right to charge your credit card or send the account to an attorney or collection agency, which may also negatively affect your credit. You will become responsible for any additional fees incurred as a result of collections (**see Collections Policy**).

Client/Parent or Guardian Initial _____ Spouse/Other Parent or Guardian Initial _____

There will be a $25 surcharge for checks returned due to non-sufficient funds.

Client/Parent or Guardian Initial _____ Spouse/Other Parent or Guardian Initial _____

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9AM and 5PM, I probably will not answer the phone when I am with a patient/client. When I am unavailable, my telephone **(480) 855-4009** is answered by the administrative assistant who knows where to reach me, or confidential voice mail that I monitor frequently, I will make every effort to return your call on the same day that you place it, with the exception of weekends and holidays. If you are having a mental health crisis, please call **(602) 222-9444**. If you are difficult to reach, please inform me of some times that you will be available. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. I do not communicate with clients via text or email unless otherwise agreed upon due to your privacy. I also will not respond to any other communication via the web, with exception to Psychology Today emails which will be responded to during regular business hours, due to your privacy and appropriate therapeutic boundaries.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you and / or your child in your / your child's Clinical Record. Except in unusual circumstances that involve danger to yourself / your child and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your / your child's Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting without charge.] In most situations, I am allowed to charge a copying fee of 25 cents per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request. You will be charged an appropriate fee for any professional time spent in responding to information requests, although I am sometime willing to conduct a review meeting without charge.

Other important information about professional treatment records includes the following:

- **Treatment records are securely stored in locked filing cabinets and / or password protected computerized files.**
- **Treatment records will be maintained by me for a period of 7 years from the date of your last clinical contact, or in the case of treatment records for children, 7 years from the date of the last clinical contact or 3 years past the child's 18th birthday, whichever is greater.**
- **After this time period has elapsed, records may be destroyed by me by way of paper shredding and / or deletion of computerized files.**
- **In the event that my office location changes or that I terminate or sell my practice at some point in the future, patient/clients whose records I am currently maintaining - my office location and/or current contact information will also be kept updated with the Behavioral Board of Health Examiners (http://www.bbhe.state.az.us/).**

PATIENT/CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

LIMITS ON CONFEDENTIALITY

The law protects the privacy of all communications between a patient/client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. **Your signature on this Agreement provides consent for those activities, as follows:**

● I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient/client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI' in my Notice of Policies and Practices to Protect the Privacy of Your Health Information).

● You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

● As required by HIPAA, I have a formal business associate contract with certain businesses in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

● If a patient/client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

● If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by applicable therapist-patient/client privilege law. I cannot provide any information without your or

your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
● If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
● If a patient/client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient/client in order to defend myself.
● If a patient/client files a worker's compensation claim, and I am providing services related to that claim, I must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.
● There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient/client's treatment. These situations are unusual in my practice.
● If I have reason to believe that a child under 18 who I have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that I file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, I may be required to provide additional information.
● If I have reason to believe that any adult patient/client who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, I may be required to provide additional information.
● If a patient/client communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and I believe that the patient/client has the intent and ability to carry out such threat, I must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient/client.
● If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

MINORS & PARENTS
Patient/clients 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 treatment records. 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 consent to give up their access to their child's records. 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 1feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

ALL CLIENTS:
With my signature, I acknowledge that I have read the above information, or it has been read to me. I acknowledge that I have received answers to my questions I may have had and that I understand the content of the information above and agree to abide by its terms during our professional relationship. I hereby authorize the release of any medical information necessary to process medical claims on my behalf, if requested by the insurer. I acknowledge that I am responsible for all services rendered to me and/or members of my family. I also understand that I am obligated to pay for all services at time of service.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE. Your signature also indicates that you consent to treatment for yourself and/or your child (children),

_____ _____
Signature of Client or Parent/Guardian Date
Printed Name: _____

_____ _____
Signature of Client or Parent/Guardian Date
Printed Name: _____

_____ _____
Therapist's Signature Date

Collections Policy

It is the policy of Dr. Chelsie Reed, PLLC. to obtain and maintain on record a valid Visa, MasterCard, American Express, or Discover Card and authorizing signature. This will remain in your confidential file as a guarantee of payment and allows the company to avoid having to take collections action against any client. **No charge will be billed to this account unless the owner of the card fails to reconcile debts to Dr. Chelsie Reed, PLLC.** If you do not wish to complete this form you may seek services elsewhere and I will assist you with a referral.

If the account is not cleared within 45 days you hereby authorize me to collect any outstanding amount on the credit card listed below. In the event charges are billed to this account, you will be sent a copy of the credit card charge and reconciled bill in the mail within 7 to 10 business days. In the event that this policy does not result in the reconciliation of your account Dr. Chelsie Reed, PLLC reserves the right to send the account to an attorney or collection agency and you will become responsible for any additional fees incurred as a result. The collection agency fee is $20 per claim.

This signed credit card collections policy is for use only for services rendered at the offices of Dr. Chelsie Reed, PLLC.

Client's Name: _____

□ VISA □ MasterCard □ Discover □ American Express

Card Member Name: _____

Card Number: _____

Expiration Date: _____Security Code: _____

Cardmember Signature: _____ Date: _____

Therapist Signature: _____

CONFIDENTIAL