Susan Warren MA, LPC, CHT
6510 N. Camino Libby, Tucson AZ 85718

Cell 520-444-7070
susankwarren@me.com
www.advancedhealingarts.net

CLIENT RECORD/INFORMED CONSENT

Name: _____ Date _____
Address: _____
City _____ State _____ Zip _____
Phone _____ Home Phone _____ Work Phone _____
Email _____
DOB _____ Age _____ Sex _____

Referred by _____ Phone _____ Physician _____ Phone _____

RELATIONSHIPS

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Relationship Type SPOUSE/PARTNER/CHILDREN	Name	Age	Living Arrangements

Housing: ☐ Own Home ☐ Rent ☐ Alone ☐ Other _____
Family Members/Roomate(s) _____ Phone _____
Pets _____ Support/Friends _____ Phone _____

WORK & INCOME

Financial Source of Income _____ Assets _____
Education _____
Work _____ How Long? _____
Other Work Experience _____ How Long? _____
Military _____ How Long? _____

HEALTH

Health Conditions _____
Illnesses Present Past
Surgeries _____ Accidents _____
Mental Health Diagnosis _____
Medications _____

Psychiatrist _____ Phone _____ Fax _____

Symptoms _____ Date Symptoms Began _____
_____
_____

Traumas _____ Date of Trauma _____
_____
_____

CLIENT RECORD/INFORMED CONSENT (CONT.)

Estimate the amount of alcohol, tobacco, caffeine, sugar you consume daily

Alcohol _____ Last Used? _____ Tobacco _____ Last Used? _____

Caffeine _____ Last Used? _____ Sugar _____ Last Used? _____

Exercise _____ How often? _____

Do you have an alcohol/drug problem? _____ Dependency? _____ Blackouts? _____

Drug(s) of choice _____

Have you ever overdosed? _____ Hospitalized? _____ When? _____

Describe your mood lately _____ Does it change often? _____ How often? _____

Have you ever thought of harming or killing yourself? _____ When? _____ Last time? _____

Are you presently involved in legal action of any kind? _____ Agency Involvement _____

What do you consider to be your ethnic/cultural heritage or background? _____

Do you have religious or spiritual beliefs or practices? _____

List any 12 Step involvement _____

Previous therapy? _____ With whom? _____ When? _____

Do you have issues with any of the following?

☐ Trauma	☐ Depression	☐ Anxiety	☐ Fears	☐ Phobias
☐ Anger	☐ Loneliness	☐ Mood Swings	☐ Impulse Control	☐ Stress
☐ Tiredness	☐ Concentration	☐ Memory	☐ Decision Making	☐ Self-Esteem
☐ Insomnia	☐ Sexual Problems	☐ Relationship Issues	☐ Abuse	☐ Food
☐ Body Issues	☐ Other			

What brings you in to counseling therapy at this time?

What are your goals in counseling?

How will you know when you've attained them?

Print _____ Date _____

Signature _____

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GENERAL CONSENT TO TREATMENT AND INFORMED CONSENT

By signing this form, I,_____ voluntarily consent to counseling for relevant treatment issues. I understand this process requires effort on my part, it may require me to face difficult issues and/or changes, and may involve risk of discomfort or no experience of change. Treatment procedures may include discussion and exploration of emotional issues, behavioral patterns, family and relational patterns, and other appropriate procedures such as Cognitive Behavioral Therapy/CBT, Eye Movement Desensitization & Reprocessing/EMDR, Brainspotting, Thought Field Therapy/TFT, Clinical Hypnotherapy, and NLP. I understand I have the right to participate in the formulation of my treatment plan as well as periodic revisions and reviews. If I require information about my treatment records, I have the right to obtain copies of my records or a treatment summary by written request. I understand I can terminate this counseling relationship at any time and can accept or decline any recommended treatment. I may withdraw this consent to treatment and will then be advised of the consequences of such withdrawal. I also understand that the therapist may terminate the professional relationship when therapeutically necessary, and other treatment options will be discussed at that time.

Current research substantiates that memories may not always be factually accurate. The meaning that one gives to their memory of events is what is important.

I understand that as I process my experiences in therapy, I may release binding, traumatic emotions, which may initially be disturbing but that I am here to learn and discover healthy ways to be with the past in the present, for the future.

I understand that information discussed during sessions is confidential and cannot be disclosed without my consent unless:

1. It is determined I am a danger to myself or to others.
2. I give my consent in writing.
3. Information is disclosed regarding child or elder abuse/neglect.
4. Disclosure is court ordered.
5. My services were obtained to enable anyone to commit or plan to commit a crime.

I understand that Susan Warren, MA, LPC, CHT participates in case consultation and may discuss aspects of my counseling work in her consultation group, and will keep identifying information about me and my counseling sessions confidential. I understand that Susan Warren cannot guarantee 100% confidentiality in phone conversations, email, Zoom, FaceTime, Skype, I-Chat, or other electronic means. Susan does not participate in legalities/court cases.

We will formulate a treatment plan, review it every 6months/1 year and make any necessary adjustments as we progress. When we terminate treatment, we will establish a discharge date and formulate an after-care plan. You have a right to refuse treatment, to withdraw informed consent for treatment in writing and Susan will inform you of any possible consequences.

Client confidentiality will be completely respected by Susan with the exception of child/adolescent/adult abuse/neglect and homicidal/suicidal ideation and any other situations the law requires to be reported. Clients will be expected to maintain the confidentiality of anyone seen or met at the counseling office. Your records will be kept for 7 years from the date of your last consultation and then will be shredded or burned.

In case of Susan's demise/retirement they will be stored/maintained through 1) Wendy Guffey MA (928) 245-6101 or 2) Anne Russell EdD (520) 954-5085 for the remaining years.

GENERAL CONSENT TO TREATMENT AND INFORMED CONSENT (cont.)

If Susan is incapacitated, she refers you to Lynn Namka, EdD, (520) 825-4766 or Anne Russell EdD (520) 954-5085 or someone in Psychology Today to continue your therapy. If you would like your records, please send Susan a signed dated letter stating that you are requesting them to be released to you. Please keep a copy of all this information for your records.

The 45-50 minute initial consultation (office/online/telephone) fee is $150, following sessions are $120 for individual, couples, family sessions, and for written reports, letters and phone calls more than 5 minutes long will be prorated at that rate. Please pay your fee (cash/checks/credit card) at the beginning of the session. If there is a financial need, a sliding fee rate from $90-$120 will be negotiated based on income, assets, or ability to pay. I prefer cash but accept checks or credit cards. There is a $5 fee for each $120 dollars charged on credit cards.

Please note and be responsible for your appointment time as I do not call to remind you of your appointment times and please be on time for your appointment. All clients will be responsible for canceling their appointments 24 hours in advance by cell phone/text 520-444-7070 or they may be charged the full fee unless there is an emergency. If you text my cell, please be sure to let me know your first name and when your appointment is. Please do not use email to cancel your appointment as I may not receive the email 24 hours in advance. If necessary, I use General Business Recoveries, INC, a collection agency.

Please be aware that if you chose to email or text me, I cannot protect your anonymity, confidentiality, or privacy.

Your credit card info will be held and charged for any no-show appointments/no 24-hour notice appointments. There will be a $20.00 charge on all returned checks plus the bank fee. My signature below indicates that I understand and will honor this policy.

Print _____ Date _____

Signature _____

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ABBREVIATED NOTICE OF PRIVACY PRACTICES (NPP) INFORMED CONSENT

My commitment to your privacy: My practice is dedicated to maintaining the privacy of your personal health information and I am required by law to do this. Please ask me any questions. I will use the information about your health that I get from you or from others mainly to provide you with treatment, to arrange payment for my services, or for some other business activities that are stated in the law as health care operations. You will need to read and sign the Consent Form so that I can treat you. If you want to disclose your information for any other purposes, I will discuss the Consent for Release of Information Form with you.

The law may require that I share your information in the following situations:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
2. I am required by law to report child abuse and elder abuse.
3. I may be required to report some types of lawsuits or legal proceedings.
4. If a law enforcement official requires that I do so.
5. For Workers Compensation and similar benefit programs.
6. Other situations like these are described in the longer version of the Information and Portability and Accountability Act.

Your rights regarding your information:

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home and not to call you at work to schedule or cancel an appointment.
2. You have the right to ask me to limit what I tell certain individuals involved in your request. If I do agree, I will keep my agreement except if it is against the law, an emergency, or if the information is necessary to treat you.
3. You have the right to look at the health information I have about you, such s your medical and billing records. You can even get a copy of these records, but I have the right to charge you for that service. Contact me, as Privacy Officer, to arrange to see your records.
4. If you believe the information in your records is incorrect to incomplete, you can ask me to make some kinds of changes (called amending) to your health information. You must make this request in writing and provide the request to me, as Privacy Officer. You must tell me the reasons you want to make any change(s).
5. You have a right to a copy of this notice. If I change this NPP, I will post the changed document in the waiting room. You may always receive a copy of this NPP from me.

You have the right to file a complaint if you believe your privacy right have been violated. You can file a complaint with me and with the Secretary of the Department of Health and Human Services in Washington, DC, Office of Civil Rights. 200 Independence Ave. S.W. Washington, D.C. 20201 (877) 696-6775 (toll free). All complaints must be in writing. Filing a complaint will not change the health care I provide you in any way. If you have any questions regarding this notice or my health information privacy policies, please contact me as Privacy Officer by phone at (520) 444-7070. Susan Warren, MA, LPC 1182, LISAC 0717

Signature _____ Date _____

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CREDIT CARD INFORMATION PRACTICE POLICY

My policy requires that I be given your updated and accurate credit card information to keep on file so that I may charge your credit card for no show appointments or no 24-hour cancellations you may have. There is a $5-8 charge per session for on credit cards in addition to your fee. I will maintain strict confidentially and will destroy your credit card information when we agree to terminate treatment. Please provide me with the following information:

Credit Card Type ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card # _____

Date of Expiration _____

3 Digit Number on Back _____

Zip Card is Registered To _____

Name on Card: _____

Address: _____

City _____ State _____

Phone _____

(Please print your name) I,_____agree to this policy and will inform Susan if my credit card information changes in any way. I agree to pay for any no-show appointments or no 24-hour notice of cancellation on my appointments. There is $5 charge on every $120 and $8 for every $150 charge for credit card usage.

Signature _____ Date _____

Therapist *Susan Warren* Date _____

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TELE-PRACTICE CONSENT

R4-6-1106. Tele-practice

Telemedicine sessions will be offered through Psychology Today's "Session" through ZOOM, or by Doxy, FaceTime or telephone and will not be conducted until I have received all necessary documentation. You may sign online and email back to me at susankwarren@me.com.

A. Except as otherwise provided by statute, an individual who provides counseling via tele-practice to a client located in Arizona shall be licensed by the Board. Susan Warren LPC 1182

B. Except as otherwise provided by statute, a licensee who provides counseling via tele-practice to a client located outside Arizona shall comply with not only A.R.S. Title 32, Chapter 33, and this Chapter but also the laws and rules of the jurisdiction in which the client is located.

C. An individual who provides counseling via tele-practice shall: 1. In addition to complying with the requirements in R4-6- 1101, document the limitations and risks associated with tele-practice, including but not limited to the following:

   a. Inherent confidentiality risks of electronic communication: Susan Warren uses a HIPAA compliant telemedicine webcam encrypted video service. No recording, record, or history of the session is made or maintained. Susan Warren will conduct telehealth sessions in a locked, private home office. It is your responsibility to assure that you are in a secure, private site during your session. Any violation of privacy/confidentiality due to you not securing private space or recording sessions (highly discouraged) is your responsibility as the client.

   b. Potential for technology failure:
   There is always the possibility that problems with the therapist's computer, client's computer, or telemedicine program could interrupt or stop a session. The session would then need be re-scheduled. If there were an issue of safety as the focus of the session the therapist would recommend continuing the session on the phone.

   c. Emergency procedures when the licensee is unavailable:
   If emergency service is required when Susan Warren is unavailable the client is required to go to the Tucson Crisis Response Center or emergency room.

   d. Manner of identifying the client when using electronic communication that does not involve video and physical location:
   Only telemedicine video sessions are offered, thus identification is simple. Physical location will be noted in the progress note.

In addition to complying with the requirements in R4-6- 1103, the following is included in the progress note required under R4-6-1103(H): a. Mode of session, whether interactive audio, video, or electronic communication; and b. Physical location of the client during the session.

Client/Guardian _____ Date _____
PRINT NAME

_____
SIGNATURE

Therapist Susan Warren Date _____

Susan Warren
SIGNATURE

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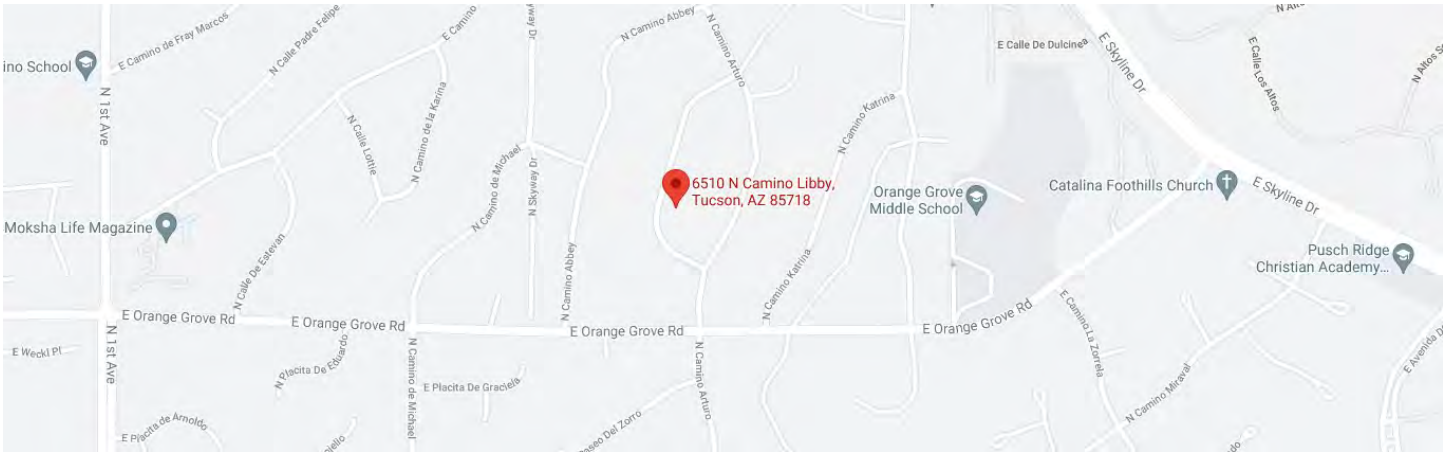
OFFICE DIRECTIONS & APPOINTMENT INSTRUCTIONS

DIRECTIONS TO OFFICE - 6510 N CAMINO LIBBY

1. Orange Grove from First Ave. or from Skyline Camino (Cmo) Arturo is halfway between Skyline and First Avenue.
2. There is a yellow crossroad sign for Cmo Arturo.
3. Turn N towards the Catalina Mountains on Camino Arturo.
   Coming from First Ave you would turn L, coming from Skyline you would turn R.
4. Take the first street L on to Camino Libby.
5. The third house on the R is 6510 Camino Libby.
6. Turn to drive up the driveway before the mailbox so you'll be facing N towards the mountains. Pull far enough forward so you can easily walk up to the carport where you'll find my office door. This is a circular driveway so it will be easy to leave as you'll just go forward and be back on Camino Libby. Go L on Libby, then R on Arturo to get back to Orange Grove.



APPOINTMENT INSTRUCTIONS

1. Please come to the carport/office door, not the front door.
2. Please ring the bell & knock as I can only hear one or the other depending on where I am. Please have a seat on the bench or if you want to wait in your car, you can text me on my cell 520-444-7070 so I'll know you are here. I will come out for you at your appointment time.
3. Please note your appointment time as I am not able to call to remind you but I am happy to write you an appointment card.
4. Please call/text 520-444-7070 to give me 24-hour notice to cancel an appointment to avoid being charged for the session. Please do not use email to cancel your appointment as I may not get it 24 hours ahead. If you choose to text my cell 520-444-7070, please make sure to let me know who is texting me. I prefer cash but also take checks, or credit cards. There is a $5 charge for each $90-150 credit card use.
5. Please be aware this is a fragrance-free environment.

Thank-you. I look forward to meeting you.

Susan