

Client Information:

Client Name: _____ Date of Birth: _____

Partner Name: _____ Date of Birth: _____

Parents Name (for minor child only): _____

Address: _____

Home Phone: _____ Cell Phone: _____
(Client) (Partner)

Email Address: _____

Employer: _____

I wish to be contacted in the following manner (check all that applies):

** Home Phone: _____ **Cell Phone: _____ **Alternative Phone Number: _____

**It is ok to leave a detailed phone message: _____ **Leave phone message with call back number only: _____

** It is ok to send me emails regarding my appointments _____ ** It is ok to text me regarding my appointment _____

In Case of Emergency:

Name: _____ Relationship: _____

Home phone: _____ Work: _____ Cell: _____

Parental Consent for Treatment of Minors:

I am the legal guardian for _____ and give consent for him /her to receive
(Name of minor child)

counseling from Cami Covey-Doucet, LPC. _____
(Legal guardian signature & relationship to minor child)

Referral Information:

Please indicate who referred you to Family Fusion:

Referral Type: self friend family healthcare provider Other

Referral Name _____

May we contact this person and thank them for this referral? Yes No

Signature of Responsible Party: _____

(Client/ Spouse/ Legal Guardian Signature)

Client Information
Please READ and SIGN

Confidentiality:

All sessions are completely confidential in accordance with law and recognized professional standards. If I, as your counselor, need to communicate to another about your case, you must give me written permission to do so. The only exception to this is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide.

Informed Consent:

Therapy is an interactive process between client and therapist and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While I will use my best effort to assist you the nature of psychological services is that there can be no assurances of results and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, intervention and discussion if these seem unclear to you.

Fee Rate:

Initial session is \$120.00 for a 45-50 minute session. The basic fee is **\$100.00 for a 45-50 minute session** for counseling. Family and Marital Sessions are **\$120.00 per 45-50 minute session.** Longer or shorter sessions are prorated from the basic fee. **After-hour phone calls:** will be billed at the fee of **\$50 for 15 minutes.** **Reports:** all reports will be billed at the fee of **\$150.00** per hour.

Payment Method:

Payment is expected at the time services are rendered, by cash, check, or credit cards. If there is a third party payer, prior arrangements must be made with written clarification of payment on file with this office. All reports, for individuals or court will not be issued until full payment for services is received.

Missed Appointments:

If you are unable to keep an appointment please notify the office immediately. If an appointment is canceled or missed without 24 hours prior notice, you will be billed for the missed session at the rate of \$60.00. Third and subsequent late cancellations will be billed the full fee and continuation with counseling will need to be evaluated.

Responsibility:

The client (or responsible party) is considered responsible for payment of professional services. When you request to bill a third party and that third party fails to make payment within 30 days from date of service, payment is expected from client or responsible party within 10 days of receipt of statement. Bills not paid within 30 days from the date of billing will be subject to an interest rate of 10% of the outstanding bill.

Consent:

I, voluntarily, agree to receive mental health assessment, care, treatment or services and authorize Cami Covey-Doucet, LPC, to provide such care. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form I acknowledge that I have read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me.

Client/Spouse or Partner Signature

Date

Therapist Signature

Date

Consent to Exchange Confidential Information

Client Name: _____

SSN _____ Date of Birth _____

I hereby authorize and request that Cami Covey-Doucet, LPC, and:

Name/Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

To exchange confidential information regarding the treatment of the above-named client from the dates of _____ to _____

Information to be exchanged:

Reason for Exchange:

___ Complete mental health records

___ Requested by client

___ Attendance and dates only

___ Phone Consultation

___ Diagnosis & Treatment Summary

___ Referral ___ Subpoena

I understand that my records are protected under Federal (42CFR Part2) and State Confidentiality Regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person that is to make this disclosure has acted on reliance on it. Authorization will remain in effect for thirty days after I sign and date this form, unless otherwise specified. Upon revocation of consent, further release of information shall cease immediately. File copy is considered equivalent to the original. This release of information expires thirty days or will automatically expire on _____.

Client Signature

Date

Parent/Guardian Signature

Date

Witness

Date

Prohibition on Redislosure:

This information has been disclosed to you from records where confidentiality is protected by Federal law. Federal regulations (42CFR Part2) prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information to criminally investigate or prosecute any alcohol or drug abuse patient is contained within (42CFR Part2 applies only to substance abuse records)

Cami Covey-Doucet, LPC

FAMILY FUSION
38 S. MacDonald Mesa, AZ 85210

480-668-1160
