Catherine E. Rosick, M.Ed., NCC, LPC
10149 N. 92nd Street, Suite 103
Scottsdale, AZ 85258
P: 602-576-4779
F: 480-284-6655

Child Client Information

***Personal Information* (All areas marked with an * MUST be completed.)**

*Child Client Name: ________________________________ Date: ____________
First MI Last

*Home Address: ____
Street City State Zip

*If Applicable:
*2nd Home Address: ____
Street City State Zip

*Mother/Guardian Name: ____
*Father/Guardian Name: ____
E-mail Address-Mother: ______________________________@__________________
E-mail Address-Father: ______________________________@__________________
Phone-Mother: (H) ________________ (W) _____________ (Cell) ______________
Phone-Father: (H) ________________ (W) _____________ (Cell) ______________
*Social Security #:____
* Date of Birth: __________ Age: _____ School: _________________Grade: _______
*Gender (circle one): Female Male
How were you referred to me? ____

***Primary Insurance Information* (All areas marked with an * MUST be completed.)**

*Insurance Company Name: ____
Insurance Company Phone #: (_______)__________________________________
*Subscriber's Name (if different): _____________________________________
*Subscriber's Date of Birth: ______ /______ /______
*Relationship to patient: _______________________
*Subscriber's Employer: ____
*Subscriber's Insurance ID#: ____
*Subscriber's Group Policy/ID #: _______________________________________
*Subscriber's Phone # (if different): (_______)____________________________
*Subscriber's Address (if different):

____
Street City State Zip

*Co-Payment Amount (Payment is required at appointment time): $ _______________
*Does the patient have an "Out-of-pocket deductible" for counseling? Yes No
*Does the patient require a "Pre-Authorization" before counseling begins? Yes No
Pre-Authorization Code (Provided by subscriber's insurance company): ______________

Concerns

Please mark all items that apply to your child

___Abuse/Violence in home
___Achievement/Motivation
___Anger
___Being bullied
___Bullying
___Conduct behavior
___Cries easily, feelings easily hurt
___Divorce issues
___Distractible, inattentive, poor concentration
___Disobedient, uncooperative, noncompliant
___Drug or alcohol use
___Eating problems
___Family/Personal drug use
___Fearful
___Fighting, hitting, violent, aggressive, hostile
___Grief/loss-Family/friend
___Incarcerated family member
___Low neighborhood attachment
___Mental health issues
___New student adjustment
___Parent remarriage/New partner
___Peer relationships
___Recent move
___Self-worth/Identity issues
___Serious illness in family
___Signs of depression
___Social skills problems
___Sleeping problems
___Suicidal thoughts or plans
___Tardiness/Attendance

Strengths

___Affectionate
___Cares for others
___Common sense
___Completes homework
___Conflict resolution skills
___Cooperation
___Creative activities
___Curiosity
___Decision-making skills
___Family expectations:
__High __Medium __Low
___Flexibility
___Future goals
___Honesty
___Involved in youth programs
___Independence
___Integrity
___Organization
___Parental support
___Other adult mentors
___Patience
___Personal competence
___Perseverance
___Positive peer influence
___Reads for pleasure
___Responsibility
___School achievement
___Self-control
___Self-motivation
___Sense of humor
___Sense of self-worth
___Shows effort

Other Concerns or Strengths:

____
____

Current Services

___After-school programs: ____
___After-school sports: ____
___Community clubs: ____
___Gifted program: ____
___Medication/s: ____
___Special education: ____

Catherine E. Rosick, LPC

ARIZONA NOTICE FORM

Notice of Counselor's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

I will also obtain an authorization from you before using or disclosing:

· PHI in a way that is not described in this Notice.

· Psychotherapy notes

III. Uses and Disclosures with Neither Consent nor Authorization

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

- *Child Abuse* – I am required to report PHI 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.
- *Incapacitated Adult Domestic Abuse* – If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult 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, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) 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, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.
- Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

- Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at 602-576-4779.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to:

10149 N 92nd Street, Suite 103
Scottsdale, AZ 85258-4557

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on September 23, 2013.

Catherine E. Rosick, LPC
10149 N 92nd St, Suite 103
Scottsdale, AZ 85258-4557
602-576-4779 Phone
480-284-6655 Fax
Child, Adolescent, Adult Psychotherapy

Acknowledgement of Receipt of Notice of Counselor's Policies and Practices to Protect the Privacy of Your Health Information

I, ____________________________________ acknowledge that I have received a copy of Catherine E. Rosick, LPC's, Notice of Privacy Practices.

This Notice describes how Catherine E. Rosick, LPC, may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

____ ____________________
Signature of Client or Representative Date

____
Relationship to Client

Catherine E. Rosick, M.Ed., NCC, LPC
10149 N. 92nd Street, Suite 103 Scottsdale, AZ 85258
P: 602-576-4779 F: 480-284-6655

INFORMED CONSENT FOR TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. All references to "my counselor" refer to me: Catherine E. Rosick, M.Ed., NCC, LPC. Please read this document carefully and ask any questions that you may have during your session. Once you initial and sign this document, it will constitute a binding agreement between us.

Please read and initial the following items:

Purpose of Treatment: The purpose of counseling is to help me meet goals to alleviate certain problems or issues that brought me into counseling at this time. Counseling is designed to assist me in developing healthier and stronger coping and problem-solving skills, and to help me live life to my full potential. My counselor and I will create a treatment plan and work toward certain goals that will be agreed upon during the counseling process.
_______ Initial

Benefits and Limitations of Treatment: Counseling is intended to help me live a happier, and healthier, life. It can help me achieve my goals, both personally and professionally, and help me have more fulfilling relationships. My counselor will work from a variety of counseling systems and will use techniques most appropriate for me and my family, if they are a part of my counseling. My counselor is a Licensed Professional Counselor (LPC) in the state of Arizona. She is able to provide counseling services that consist of individual, family, and relationship counseling. Of course, counseling requires a very active effort from all participants in the counseling relationship. Attempting to resolve issues that brought me into counseling in the first place may result in changes that were not originally foreseen. My counselor reserves the right to recommend a referral as she feels that this is in my best interest as the client, or parent of my minor child/children.
_______ Initial

My Rights as a Counseling Client: I have chosen to receive individual, couples, and/or family counseling. I understand that my choice has been voluntary and that I may terminate therapy at any time. I understand that counseling is a collaborative effort between my counselor and me. I understand that I have the right to be informed of the various steps and activities involved in receiving counseling services. I will attempt to work with my counselor to develop and follow a plan of treatment. I also understand that I have the right to make an informed decision whether to accept or refuse treatment. I also have the right to refuse any recommended treatment and to complete services at any time. I have received a form in this packet explaining my rights and responsibilities. After reading this form, I may ask any questions needed to fully understand my rights and responsibilities. I can address any concerns or grievances with my counselor. I may also contact the Arizona Board of Behavioral Health, the licensing board that regulates the counseling profession.
_______ Initial

Potential Risks of Treatment: I understand that there is no assurance that I will feel better, and that material may be discussed that could be upsetting in nature. There are no guarantees that I will find counseling to be effective or useful. Moreover, the process of counseling usually involves working through difficult personal issues that can result in some emotional or psychological discomfort.
_______ Initial

My counseling will begin with an initial assessment, conducted by my counselor, to gain better understanding of the issues, history, and any other relevant factors. When the initial assessment is complete, my counselor will develop a treatment plan. She will review it with me. I will help make decisions and participate in the process of creating the treatment plan.
_______ Initial

State and Federal laws protect the confidentiality of all counseling interactions. Unless I grant written permission, my counselor will neither inform anyone that I, and/or members of my family, are receiving counseling, nor will my counselor disclose the content of any session. However, there are circumstances that impose on my right or ability to maintain a privileged communication. These circumstances include: medical emergencies; the existence of a threat of danger to self or others; reasonable suspicion of current physical/sexual abuse of a child or elder; abandonment or neglect; a court order; receipt of a properly executed consent form; and where otherwise legally required. If I choose to invite a family member, or friend, into my sessions, I will sign a Visitor in Session form.
_______ Initial

I consent to my counselor videotaping or recording my counseling sessions.
N/A

I understand that counseling sessions, billed through my insurance, are 45-50 minutes for individual sessions and 50 minutes for couple's and family sessions. Private pay counseling sessions are all 50 minutes.
_______ Initial

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INFORMED CONSENT FOR TREATMENT
PAGE TWO

The fee for each 50-minute private pay session is $120.00. I understand that I am expected to pay at the time services are rendered. Payment can be made by cash, check, or credit card (American Express, Discover, MasterCard, and Visa). If I am using my insurance, I understand that I am responsible for all co-pays, co-insurance, and yearly deductibles. Telephone calls, consultations with other professionals, and written reports of less than 15 minutes each that are conducted by my counselor, are at no charge to me. Those services exceeding 15 minutes are billed at the 50-minute private pay rate of $120 and are not reimbursed by insurance. I have been given a separate Fee Schedule form which explains all fees associated with my counseling.
_______ **Initial**

I understand that, at times, it may be necessary to cancel my appointment. Any changes or cancellations must be made at least 24 hours before my scheduled appointment, except in the case of illness. Insurance does not cover cancellation fees for missed appointments. I will be charged $50.00 for cancellations made less than 24 hours before my scheduled appointment, for reasons other than illness, or if I do not show up for my scheduled appointment.
_______ **Initial**

Two notices are sent to me through the online Yellow Schedule appointment confirmation program. An email is sent to me 48 hours prior to my appointment. A text is sent to my cell phone 24 hours prior to my appointment. I agree to receive these electronic reminders for my appointments and to confirm or cancel my appointments. Successful transmission of the email and text reminders cannot be guaranteed. I am responsible for remembering the date and time of my appointment.
_______ **Initial**

I understand that there are limitations and risks associated with providing treatment via electronic media. I consent to receiving texts, emails, and phone messages from my counselor regarding all aspects of my treatment.
_______ **Initial**

My counselor is required by law to keep records. I am entitled to review or receive my records, or the records of my minor child/children, at my request, in writing. I understand that it is beneficial to meet with my counselor to review these records, or to obtain a written summary since counseling session notes may be difficult to read or interpret. I also understand that there will be a $25.00 fee charged for record copying and release. This must be done in my counselor's office, or electronically, with a written and signed request.
_______ **Initial**

In the event of my counselor's incapacity, or death, my records will be transferred to a local mental health professional to facilitate continuation of treatment. In such a situation, I have the right to continue treatment with this professional, discontinue treatment, or ask for a referral to another mental health professional. If I am an inactive client (I have not been currently seeing my counselor for counseling), my records will be handled by a "records custodian" who may be another mental health professional, or agency. The custodian will be responsible for satisfying records requests and destroying records when the legal time frames for record retention are satisfied. (ARS 12-2297. Retention of Records.)
_______ **Initial**

My counselor is often not immediately available by telephone. When she is unavailable, her telephone is answered by an automated voice messaging system, which she monitors during daytime hours, seven days a week. Messages are not checked from 8:00pm-8:00am. My counselor will make every effort to return my call within one (1) business day. She may email, or text me, or leave a voice message on my home/cell/work phone. If I am difficult to reach, I can leave the times that I will be available. If my situation is an emergency, I can call 911, Value Options Crisis Line at 602-222-9444, Teen Lifeline at 1-800-784-8336, or EMPACT Suicide Hotline at 480-784-1500.
_______ **Initial**

****

I have reviewed the information on these pages, and have had questions answered to my satisfaction, and therefore accept these provisions. I agree to have myself and/or my minor child/children participate in therapy.

Client Name (Please Print) ____________________________________

Client Signature____ Date___________________

Parent/Guardian Signature_____________________________________ Date_____________________
(If client is a minor)

Catherine E. Rosick, M.Ed., NCC, LPC

10149 N. 92nd Street, Suite 103 Scottsdale, AZ 85258
P: 602-576-4779 F: 480-284-6655
www.azchildcounselor.com cathyrosick@cox.net

FEE SCHEDULE

Revised 12/01/11

50-Minute Session - Private Pay (Insurance clients are responsible for deductibles and co-pays)	$120
Late Cancellation (Less than 24 hrs. notice)	$50
Missed Appointment	$50
Copying of File	$35 per requested client
Report/Letter Writing	$120/hr.
Trial/Deposition Preparation	$120/hr.
Deposition	$120/hr.
Court Appearance (Minimum 4 Hours) Paid prior to appearance	$120/hr.
Travel Time	$120/hr.
Telephone and Email Consultations with clients, parents/guardians, parenting coordinators, case workers, legal counsel, and other professionals (Over 15 minutes)	$120/hr.

Client Name (Please Print) ____

Client Signature ______________________________ Date __________

Parent/Guardian Signature _____________________ Date __________
(If client is a minor)