FAMILY STRATEGIES COUNSELING CENTER

1745 S Alma School Rd., Suite 230, Mesa, AZ 85210
(Just South of the 60. Southeast corner of Alma School and Isabella)
Phone: 480-668-8301 FAX 480-558-3020

NEW CLIENT INFORMATION *(Please Print Clearly)* *(Revised 7/30/18)*

CLIENT NAME: _____ _____ _____
First **Last** Date of Birth: (MM/DD/YYYY) Age

Parent(s) Name (for minor child only):_____
NOTE: If parents are divorced, court custody documents must be provided prior to the first session.
If parents share joint custody, both must sign the "Client Consent" form.
Current school *(if applicable)*: _____ Grade: _____

ADDRESS: _____
City State Zip

Gender: ____Male ____Female Employer: _____ Occupation: _____

CURRENT STATUS: Married: _____ Single: _____ Divorced: _____ Separated: _____ Widow/Widower: _____

Who do you authorize Family Strategies to speak with about your schedule appointments? _____
Who do you authorize Family Strategies to speak with about your account financial matters? _____

Their relationship to you: _____ Your signature _____

Text/Cell number: _____ Home Phone: _____
If someone needs to call you, please indicate which number to use: _____ Cell _____ Home _____ Either

Email Address: _____
You will receive periodic emails about our services and specialty programs. If you do not wish to receive these, please use the "unsubscribe" link in those periodic emails. We DO NOT sell or provide emails to others

What would you prefer your username be for our Patient Portal? _____

EMERGENCY CONTACT

Name: _____
First Last Phone

EXCHANGE OF CONFIDENTIAL INFORMATION

In efforts to provide me with the best possible care, I hereby authorize my therapist to exchange confidential information regarding my treatment to ***other professional staff at Family Strategies***. Professional staff includes, but are not limited to, the Clinical Director, Clinical Supervisors, and other therapists who have expertise regarding specific clinical issues and treatment planning. I give this authorization of my own free will and have discussed any questions or concerns with my therapist. By signing this consent to exchange confidential information, I acknowledge that I have both read, understood and that I agree to all the terms of this release. I understand that my records are protected under Federal and State Confidentiality Regulations.

_____ Date _____
Signature of Client or Legal Guardian if client is under the age of 18

HOW DID YOU HEAR ABOUT FAMIILY STRATEGIES? _____

THERAPIST YOU ARE SCHEDULED TO SEE: _____

WERE YOU REFERRED? ____ Yes ____ No

IF YES, WHOM MAY WE THANK? _____

FINANCIAL RESPONSIBILITY

Name: _____ _____ _____ _____
Last First Relationship Date of Birth

Address: _____
City State Zip

Phone: _____
Home Work Mobile

Email Address: _____

I accept full responsibility for all fees due to professional services. I realize that any third party billing is out of courtesy to me and does not transfer any financial responsibilities for unpaid services.

If I have Blue Cross Blue Shield Insurance, I understand that I am responsible for any allowable amount that BCBS does not cover.

If you as client are an adult and a family member or friend is providing payment in your behalf, do you authorize Family Strategies to speak with them regarding the financial aspect of your account?

_____Yes _____ No

Signature of Responsible Party ***(Required):*** _____ Date: _____

BCBS INSURANCE CLIENTS ONLY. **All Information is Required.**

PRIMARY INSURED : _____ RELATIONSHIP TO CLIENT: _____

PRIMARY INSURED DATE OF BIRTH: _____ GENDER: M / F SSN: __ __ __ - __ __ - __ __ __ __

PRIMARY INSURED ADDRESS_____
Street City State Zip

PRIMARY INSURED EMPLOYER: _____

GROUP #: _____ SUBSCRIBER #: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AT FIRST APPPOINTMENT.

PLEASE STATE THE REASON YOU ARE SEEKING COUNSELING

_____

_____

BEHAVIORAL HEALTH HISTORY:

Do you have a history of depression? _____ Yes _____ No
Have you ever taken medication for depression? _____ Yes _____ No

Does any member of your family have a history of depression? _____ Yes _____ No
Does any member of your family have a history of mental illness? _____ Yes _____ No

Have you **previously** received help through counseling? _____ Yes _____ No
If yes, who was your therapist? _____
Are you **currently** working with another therapist? _____ Yes _____ No
If yes, what is this therapist's name? _____
Do you authorize Family Strategies to communicate with this therapist? _____ Yes _____ No. I do NOT authorize

Your signature: _____

OVERVIEW OF MEDICAL HISTORY:

Do you have a Primary Care Physician? _____ Yes _____ No
PCP Name: _____ Phone: _____
What is the date of your last physical exam? _____
Do you authorize Family Strategies to communicate with your PCP? _____ Yes _____ No. I do NOT authorize

Your signature: _____

Please list any hospitalizations in the last year: _____

Please check (✓) if you currently have, or have had, any symptoms or problems in any of the following areas to a significant degree:

☐ Chest/heart ☐ Head/Brain Injury ☐ Neck ☐ Intestinal ☐ Kidneys
☐ Lungs/Respiratory ☐ Ear/Nose/Throat ☐ Back ☐ Skin ☐ Reproductive
☐ Bladder ☐ Bowel ☐ Other: _____

Please, briefly describe your symptoms:

Have you had, or do you currently have, any medical conditions or diseases? Please list: _____

_____

Please list the medical conditions your parents, grandparents or siblings have had or currently have and indicate which family member:

Please list any medications you currently take **and** the condition for which you take them:
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____

Please list any medications you are allergic to: _____

Do you currently have an infectious disease? _____ Yes _____ No

This is a self-report – Please note any that apply:
____ Strep ____ Lice ____ HIV ____ STD ____ Chicken Pox ____Measles, Mumps, Rubella ____ Bed Bugs
____ Other: (Please list) _____

Do you have a learning disability?
____ ADHD ____ APD ____Dyscalculia ____ Dyspraxia ____ Dysraphia ____ Dyslexia ____ LPD ____ Memory
____ Language Processing Disorder ____ Non-Verbal Learning ____ Visual Perception/Visual Motor Deficit
____ Other: _____

HEALTH HABITS:

____ Yes ____ No Do you drink Alcohol? If yes, how much alcohol? _____/day/week/month
____ Yes ____ No Do you smoke cigarettes? If yes, how much and how often? _____/day _____ # years
____ Yes ____ No Do you have a history of substance abuse?
____ Yes ____ No Are you addicted to or abuse legal or illegal drugs?
____ Yes ____ No Do you drink caffeinated beverages? If yes, how much and how often? _____/day
____ Yes ____ No Do you have problems with eating or your appetite?
____ Yes ____ No Do you exercise regularly?
____ Yes ____ No Do you feel comfortable with your weight?
____ Yes ____ No Do you have trouble sleeping?
____ Yes ____ No Have you ever had a seizure?
____ Yes ____ No Do you have a history of head injuries or concussions? If yes, when _____

CHILD/ADOLESCENT HEALTH HISTORY: *only if client is under the age of 18*

Who lives in the home? (Name, Age and Relationship)

____ Yes ____ No Are there pets in the home? If yes, what type? _____

PRENATAL HISTORY: (biological mother of minor client listed on page 1)

During Pregnancy	No	Yes	Describe
Medical conditions			
Emotionally stressful			
Tobacco/Cigarette Use			
Alcohol Use			
Substance/Drug Abuse			

Birth	No	Yes	Describe
Premature			
Full Term			
Vaginal Delivery			
C-Section			
Birth Weight			
Birth Injury			
Oxygen after delivery			
Admit to Newborn ICU			
Infection			
Jaundice			
Seizures			
Birth Defects			
Feeding Problems			
Post Partum Depression			
Other			

If you need to reschedule or cancel appointment (remember our 24-hour policy), please call our Client Care Specialists at 480-668-8301, x 1001.
If you need to reach our Billing Department (including questions about insurance), please call 480-668-8301, x 1003.
If you need to reach the Office Manager, please call 480-668-8301, x 1002.
We look forward to serving your behavioral health needs.

If you need immediate or emergency mental health care, please call the Behavioral Health Crisis Line at 602-222-9444.
THIS NUMBER IS NOT ASSOCIATED WITH FAMILY STRATEGIES COUNSELING CENTER.

FAMILY STRATEGIES COUNSELING CENTER

CLIENT CONSENT

Please READ and SIGN

(Revised 9/29/2017)

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 are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide. Insurance companies are entitled to diagnosis, date, and type of service. All therapeutic services via online, phone, VSee or similar medium is provided adhering to the laws of the state of Arizona and the Arizona Board of Behavioral Health; we are licensed within the state of Arizona and assert that services are being provided within the state of Arizona where the therapist resides and is licensed to practice.

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 the therapist will use best effort to assist you, 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. My signature below indicates that I understand that there are risks for noncompliance with treatment recommendations, and that I will discuss these risks with my therapist.

CLINICAL SUPERVISION

Your therapist _____ is under clinical supervision as an associate licensed counselor with the Arizona Board of Behavioral Health, or is a University intern studying for a Masters Degree, and provides therapy under the clinical supervision of Floyd Godfrey, LPC who is qualified to provide supervision within the state of Arizona according to the laws and regulations set forth by the Arizona Board of Behavioral Health. You can contact him by calling 480-668-8301.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that this often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce, custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call upon any employee, therapist or staff member associated with Family Strategies & Coaching, LLC, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

PAYMENT & MISSED APPOINTMENTS

Payment is expected at the time services are rendered, by cash, check or credit. If you are unable to keep an appointment, please notify your counselor as soon as possible. If an appointment is canceled or missed **without 24 hours prior notice, you will be billed at regular session fees.**

FINANCIAL RESPONSIBILITY

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

INFORMED CONSENT

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such. 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 both read, understood and that I agree to 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. I also acknowledge that I have received a copy of "Client Rights" and "Complaint/Grievance Procedures."

_____	_____	_____
(Client Signature)	(Print Name)	Date
_____		_____
(Therapist Signature)		Date

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I,_____ am the parent or legal guardian with legal custody of _____ and
(Print Parent/ Guardian Name) (Child Name)

give permission to provide counseling services to my child. _____ _____
(Parent Signature) (Date)

FAMILY STRATEGIES
COUNSELING CENTER

Authorization for Automatic Debit/Credit Card Payments

(Revised 2/7/19)

Client Name: _____ **Phone:** _____

Parent/Guardian Name: (If applicable) _____

INDIVIDUAL THERAPY:

By my signature below, I authorize FAMILY STRATEGIES COUNSELING CENTER (Floyd Godfrey, LPC) to debit/charge the account number I have specified below:

* At the time of service when I check in at the front desk, OR
* For missed appointments**,** OR
* For late cancelations. (Late cancelations are defined as up to 24 hours prior to my appointment.)

Please be considerate of your therapist's time and abide by our 24-hour cancelation policy. If you notify us of a cancelation before 24 hours, it will allow us to schedule other clients seeking services here at Family Strategies.

Having a card on file to use for your sessions **is required** *and will enable us to expedite your check in time and reduce overhead allowing us to keep fees as low as possible.*

☐ OPT OUT: PLEASE CHECK THIS BOX IF YOU WANT YOUR CARD TO BE CHARGED FOR NO SHOWS OR LATE CANCELATIONS ***ONLY***.

☐ OPT IN: PLEASE CHECK THIS BOX IF WE MAY **PRECHARGE** YOUR CARD WHEN YOU ARE SCHEDULED AT A TIME WHEN NO RECEPTIONIST IS AVAILABLE AT THE FRONT DESK (i.e. Saturdays, late or early hours.)

One week's written notice will be needed to cancel this authorization.

SIGNATURE : _____ **DATE:** _____

CREDIT CARD INFORMATION: **Please check box:** □**VISA** □**MasterCard** □**Discover Card** □**Amex**

Name as it appears on the card: _____

Credit Card #: _____

Expiration Date: _____ CVV# *on the back of the card*: _____

THIRD-PARTY PAYERS: If a third party pays for all or a portion of your session fees, **we must have a signed Third-Party Agreement on file for you**. Please ask for this form at the front desk from the receptionist. Your credit card will not be charged unless your account is 60 days past due or beyond. We will contact you before charging your card.

Third-Party Payer Name: _____ Relationship to You: _____

Address: _____
Street *City* *State* *Zip*

Phone: _____ Third-Party Payer Email: _____