# Carolyn Settle, M.S.W., L.C.S.W.

## Patient Registration

**Patient Information**

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

SS #: _____ Sex: M F Marital Status: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Message OK? ❑ Yes ❑ No Message OK? ❑ Yes ❑ No Message OK? ❑ Yes ❑ No

Occupation: _____ Employer: _____

Emergency Contact & Phone: _____ Relationship to Patient: _____

The cost of this service is your responsibility. Payment is expected at the time of service. I will provide a superbill for submission to your insurance company.

**24 Hour Cancellation Notice:** A charge will be made for appointments missed or cancelled less than 24 hours in advance without good cause. Insurance does not cover missed appointments.

Telephone Calls: Telephone calls to your therapist which exceed **5 minutes** will be charged directly to you. Insurance companies do not pay for phone calls.

**ADMINISTRATIVE CHARGES** will be applied when you request information to be sent or reviewed. It is your responsibility to verify these charges at the time of your request.

A FEE OF $35.00 WILL BE CHARGED FOR RETURNED CHECKS.

I understand that by signing below I waive my right to confidentiality in the collection of any fees in dispute for services rendered.

I have read and understand the above.

_____

Signature – Patient or Parent/Guardian Date

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS IMPORTANT INFORMATION. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.

Copy to Client: _____

# Carolyn Settle, M.S.W., L.C.S.W.

## Confidential History

**Name:** _____

Education Level: _____ Current Occupation: _____

Satisfied with your occupation? ❑ Yes ❑ No Comment: _____

Ethnicity: _____ Religion: _____

Sex: M F Age: _____ Language spoken at home? ❑ English ❑ Other: _____

**Marital Status** (Check all that apply): Years Married: _____
❑ Married ❑ Living together ❑ Never married ❑ Divorced ❑ Separated
❑ Custodial parent remarried ❑ Non-custodial parent remarried
Are there current marital problems? ❑ Yes ❑ No Comments: _____

**Spouse's Name:** _____ Highest level of education: _____

Occupation: _____ Satisfied with job? ❑ Yes ❑ No

**Children**
Name: _____ Sex: M F Age: _____

Name: _____ Sex: M F Age: _____

Name: _____ Sex: M F Age: _____

**Mother's Name:** _____ Stepmother? ❑ Yes ❑ No

Occupation: _____ Highest level of education: _____

**Father's Name:** _____ Stepfather? ❑ Yes ❑ No

Occupation: _____ Highest level of education: _____

**Siblings**
Name: _____ Sex: M F Age: _____

Name: _____ Sex: M F Age: _____

Name: _____ Sex: M F Age: _____

With whom were you raised? (Check all that apply)
❑ Biological parents ❑ Parent and step-parent ❑ Foster parents ❑ Single parent
❑ Adoptive parents ❑ Relatives ❑ Institution ❑ Legal guardian ❑ Other: _____

Marital Status of Parents (Check all that apply) Years Married: _____
❑ Married ❑ Living together ❑ Never married ❑ Divorced ❑ Separated
❑ Custodial parent remarried ❑ Non-custodial parent remarried
Comments: _____

Please list any major medical conditions in your family: _____

_____

_____

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**Your medical conditions or health issues:** _____

_____

_____

Current Physician: _____ Phone #: (_____) _____ - _____

Date of most recent visit: _____ Reason: _____

Medications you take: ❑ I do not take prescription medication at this time

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Medication: _____ For what condition: _____

Please describe other serious illnesses or injuries: _____

_____

Is there any family history of treatment for psychological/psychiatric conditions? ❑ Yes ❑ No

Comments: _____

Have you had previous counseling or psychotherapy? ❑ Yes ❑ No

With whom and when: _____

_____

Have you ever felt suicidal? ❑ Yes ❑ No Do you feel that way now? ❑ Yes ❑ No

Comments: _____

**Are you involved in any legal proceedings?** ❑ Yes ❑ No Comments: _____

_____

Have you ever been arrested? ❑ Yes ❑ No Have you ever been convicted of a crime? ❑ Yes ❑ No

Comments: _____

Do you drink alcohol? ❑ Yes ❑ No What type: _____ Frequency: _____

Do you use tobacco? ❑ Yes ❑ No What type: _____ Frequency: _____

Do you use other drugs? ❑ Yes ❑ No What type: _____ Frequency: _____

**What are your main concerns/reasons for seeking treatment?** _____

_____

_____

Did a specific event lead to this session? ❑ Yes ❑ No Comments: _____

_____

Have you been a victim of physical or sexual abuse/assault? ❑ Yes ❑ No Comments: _____

_____

Is there anything significant the form did not ask that you would like to add? _____

_____

# TREATMENT PLAN
(Please fill out up to the dark line.)

Name_____Date_____

Treatment Goal(s)
(Check all those that apply)

__Stabilize/improve mood & functioning __Debrief & resolve trauma __Debrief & resolve

__Learn to manage/reduce symptoms __Anger management __Stress management

__Relationship skill building __Learn to identify/express feelings & needs directly

__Educate/increase personal empowerment __Assess/address interpersonal relationship issues

__Achieve/maintain sobriety __Learn to identify/set boundaries assertively

__Other

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Treatment Methods
(Check all those that apply)

__Individual therapy __Family therapy __Group therapy

__Conjoint therapy __Other

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Signatures

X_____
Signature Date Client/parent/guardian (print)

X_____Carolyn Settle, MSW, LCSW_____
Signature Date Clinician

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Diagnosis_____

Treatment Plan Review
Treatment plan reviewed annually—signed and dated if no changes to plan (if changes, new treatment plan written)

Client:
1)_____ 2)_____3)_____
Sign and date Sign and date Sign and date

Clinician:
1)_____ 2)_____3)_____
Sign and date Sign and date Sign and date

Aftercare needed after discharge, if discharge date has been determined:

__Community resources __PCP/Psychiatrist/NP __12 Step program

__Other

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## INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES & OFFICE POLICIES

**This form provides you (patient) with information that is additional to that detailed in the Notice of Privacy Practices. Please initial each paragraph in the space provided indicating that you have read and understood the content of that paragraph.**

**CONFIDENTIALITY:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (patient's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form. Initial: _____

**When disclosure is required by law:** Some of the circumstances where disclosure is required by law are: when there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a patient presents a danger to self, to others: or is gravely disabled (see also Notice of Privacy Practices form)
Initial: _____

**When disclosure may be required:** Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your therapist will not release records to any outside party unless they are authorized to do so by **all** adult family members who were part of the treatment. Initial: _____

**Health insurance & Confidentiality of records:** Disclosure of confidential information may be required by your health insurance carrier, HMO/PPO/MCO/EAP, or other third party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly the Psychotherapy Notes will not be disclosed to your insurance carrier. Your therapist has no control or knowledge over what insurance companies do with the information they submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information, including a diagnosis, is entered into insurance companies' computers and will also be reported to the Congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position. Initial: _____

**Confidentiality of E-mail, cell phone, and faxes communication:** It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify your therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail or faxes for emergencies. Initial: _____

**Consultation:** Your therapist may consult with other professionals regarding their patients; however, the patient's name or other identifying information is never mentioned. The patient's identity remains completely anonymous, and confidentiality is fully maintained. This is done to provide you with the best care possible.
Initial: _____

**THE PROCESS OF THERAPY:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Psychotherapy requires your very active involvement, honesty, and openness in order to change. Your therapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. During therapy, remembering or talking about painful memories, unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings. This may include anger, sadness, worry, fear, shame, anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions and/or perceptions and propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing perceptions, beliefs, behaviors, employment, substances use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and their assessment of what will best benefit you. Sometimes more than one approach can be helpful in dealing with a certain situation. These approaches may include, but are not limited to: cognitive-behavioral, psychodynamic, EMDR, behavioral, existential, systems/family of origin, developmental (adult/child/family), biblio-therapy, or psycho-educational. Initial: _____

**Discussion of treatment plan:** Within a reasonable period of time after the initiation of treatment, your therapist will discuss with you their working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about the course of your therapy, the possible risks, your therapist's ability, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your therapist does not provide, they have an ethical obligation to assist you in obtaining those treatments. Initial: _____

**Termination:** You have the right to terminate therapy at any time. Ideally, this happens when the goals of therapy have been met. If at any point during psychotherapy, your therapist believes they are not effective in helping you reach the therapeutic goals, they are obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, they would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your therapist will talk to the new psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and with your written consent will provide him or her with the essential information needed. Initial: _____

**Dual relationships:** A dual relationship exists when you have some type of relationship with your therapist outside the clinical setting. This may include civic and philanthropic groups, religious communities, sports leagues, etc. Appropriate dual relationships are not unethical. Therapy never involves sexual or any other dual relationship that can be exploitative in nature, or impairs your therapist's objectivity, clinical judgment, and/or therapeutic effectiveness. Appropriate non-sexual dual relationships can be clinically beneficial and may, in fact, be the reason you chose your therapist. Your therapist will discuss with you the potential benefits and difficulties that may be involved in dual relationships and will discontinue the dual relationship if it interferes with the effectiveness of the therapeutic process. Initial: _____

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact your therapist between sessions, please leave a message on your therapist's voice mail. In case of medical emergency, or when there is immediate danger or potential for harm, call 911. Or, if you have an emotional emergency, call the Banner Helpline at (602) 254-4357. Initial: _____

**PAYMENTS & INSURANCE REIMBURSEMENT:** Patients are expected to pay the standard fee of $160.00 per 45-50 minute session and $240.00 per 80-90 minute session at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, individual consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Initial: _____

**CANCELLATION:** Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment. The full fee will be charged for sessions missed without such notification. Initial: _____

**I have read the above Informed Consent for Psychotherapy Services & Office Policies carefully; I understand them and agree to comply with them.**

_____ Relationship to patient: _____
Signature Name (print) Date

_____ Relationship to patient: _____
Signature Name (print) Date

_____ Relationship to patient: _____
Signature Name (print) Date

_____
Therapist signature Date

Carolyn Settle, M.S.W., L.C.S.W.

# HEALTH INFORMATION PORTABILITY & ACCOUNTABILITY ACT NOTICE OF PRIVACY PRACTICES

**This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.**

## It Is Your Therapist's Legal Duty to Safeguard Your Protected Health Information (PHI).

By law your therapist is required to insure that your PHI is kept private. The PHI constitutes information created or noted by your therapist that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. Your therapist is required to provide you with this Notice about their privacy procedures. This Notice must explain when, why, and how your therapist would use and/or disclose your PHI. Use of PHI means when your therapist shares, applies, utilizes, examines, or analyzes information within the practice; PHI is disclosed when your therapist releases, transfers, gives, or otherwise reveals it to a third party outside the practice. With some exceptions, your therapist may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, your therapist is always legally required to follow Arizona law and the privacy practices described in this Notice.

Please note that your therapist reserves the right to change the terms of this Notice and the privacy policies at any time. Any changes will apply to PHI already on file with your therapist. Before your therapist makes any important changes to the policies, they will immediately change this Notice and post a new copy of it in the office. You may also request a copy of this Notice from your therapist, or you can view a copy of it in the office.

## How Your Therapist Will Use And Disclose Your PHI.

Your therapist will use and disclose your PHI for many different reasons. Most of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of your therapist's uses and disclosures, with some examples.

**Uses and Disclosures Related to Treatment, Payment, or Health Care Operations That Do Not Require Your Prior Written Consent:**

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.** Your therapist may make a disclosure to the appropriate officials when the law requires them to report information to courts, government agencies, law enforcement personnel, and/or in an administrative proceeding. This includes search warrants and court orders for release of records. If you, or anyone else, places your mental condition as part of any litigation (such as divorce, custody, or personal injury), your therapist may be compelled to release your PHI.
2. **Disclosure is compelled or permitted when you are in such mental or emotional condition as to be dangerous to yourself and if your therapist determines that disclosure is necessary to prevent potential harm.** For example, suicidal or serious self-destructive behavior.
3. **Disclosure is mandated by the Arizona Child Abuse and Neglect Reporting law.** For example, if your therapist has a reasonable suspicion of child abuse or neglect.
4. **Disclosure is mandated by the Arizona Elder/Dependent Adult Abuse Reporting law.** For example, if your therapist has a reasonable suspicion of elder abuse or dependent adult abuse.
5. **Disclosure is mandated when you tell your therapist of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.** Also, confidentiality does not apply to disclosure of crimes planned for the future. This applies to interests of national security, such as protecting the President of the United States or assisting with intelligence operations to prevent future terror activities.
6. **When disclosure is required to obtain payment for treatment.** Your therapist might send your PHI to your insurance company, health plan, or other third party payer in order to receive payment for services your therapist provided to you. Your therapist may also provide your PHI to business associates, such as billing companies or others that process health care claims for the office.

7. **Appointment reminders and health-related benefits or services.** Your therapist may use PHI to provide appointment reminders. Your therapist may use PHI to give you information about alternative treatment options, or other health care services or benefits your therapist offers.
8. **When disclosure is otherwise specifically required by law.**

**Other Uses And Disclosures Require Your Prior Written Authorization.** For situations not described above, your therapist will require written authorization before disclosing any of your PHI. This includes communication with family members or other health care providers. Even if you signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future disclosures.

## What Rights You Have Regarding Your PHI:

**The Right to See and Get Copies of Your PHI.** In general, you have the right to see your PHI that is in your therapist's possession, or to get copies of it; however, you must request it in writing. You will receive a response from your therapist within 5 days of receiving your written request. Under certain circumstances, your therapist may deny your request. If they do, your therapist will give you, in writing, the reasons for the denial. You have the right to have the denial reviewed. If you ask for copies of your PHI, you will not be charged more than $.25 per page. Your therapist may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as the cost, in advance.

**The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that your therapist limit how your therapist uses and discloses your PHI. You do not have the right to limit the uses and disclosures that they are legally required or permitted to make.

**The Right to Choose How Your PHI is Sent to You.** It is your right to ask that you PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via e-mail instead of by regular mail).

**The Right to a List of the Disclosures Your Therapist Has Made.** You are entitled to a list of disclosures of your PHI that your therapist has made after April 15, 2003. The list will not include uses or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

**The Right to Amend Your PHI.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that your therapist correct the existing information or add the missing information. Your request must be made in writing. Your therapist may deny your request, in writing, if you therapist finds that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of their records, or (d) written by someone other than your therapist. Your therapist's denial must be in writing and must state the reasons for the denial. You have the right to file a written statement objecting to the denial. You have the right to ask that your request and the denial be attached to any future disclosures of your PHI. When approved, your therapist will advise others who need to know about the change to your PHI.

**The Right to Get a Copy of This Notice.** You have the right to get this notice by e-mail or paper hard copy.

## How To Complain About Your Therapist's Privacy Practices:

If, in your opinion, your therapist may have violated your privacy rights, or if you object to a decision your therapist made about access to your PHI, you are entitled to file a complaint with your therapist or if applicable, their clinical supervisor. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about privacy practices, your therapist will take no retaliatory action against you.

**This Notice Is In Effect From April 14, 2003.**

**I acknowledge the terms of this notice and the privacy practices of this office.**

_____ Relationship to patient: _____
Signature Name (print) Date

_____ Relationship to patient: _____
Signature Name (print) Date

_____ Relationship to patient: _____
Signature Name (print) Date