

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

- | | |
|--|--|
| <input type="checkbox"/> Abuse/Violence in home | <input type="checkbox"/> Grief/loss-Family/friend |
| <input type="checkbox"/> Achievement/Motivation | <input type="checkbox"/> Incarcerated family member |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Low neighborhood attachment |
| <input type="checkbox"/> Being bullied | <input type="checkbox"/> Mental health issues |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> New student adjustment |
| <input type="checkbox"/> Conduct behavior | <input type="checkbox"/> Parent remarriage/New partner |
| <input type="checkbox"/> Cries easily, feelings easily hurt | <input type="checkbox"/> Peer relationships |
| <input type="checkbox"/> Divorce issues | <input type="checkbox"/> Recent move |
| <input type="checkbox"/> Distractible, inattentive, poor concentration | <input type="checkbox"/> Self-worth/Identity issues |
| <input type="checkbox"/> Disobedient, uncooperative, noncompliant | <input type="checkbox"/> Serious illness in family |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Signs of depression |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Social skills problems |
| <input type="checkbox"/> Family/Personal drug use | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Suicidal thoughts or plans |
| <input type="checkbox"/> Fighting, hitting, violent, aggressive, hostile | <input type="checkbox"/> Tardiness/Attendance |

Strengths

- | | |
|---|--|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Integrity |
| <input type="checkbox"/> Cares for others | <input type="checkbox"/> Organization |
| <input type="checkbox"/> Common sense | <input type="checkbox"/> Parental support |
| <input type="checkbox"/> Completes homework | <input type="checkbox"/> Other adult mentors |
| <input type="checkbox"/> Conflict resolution skills | <input type="checkbox"/> Patience |
| <input type="checkbox"/> Cooperation | <input type="checkbox"/> Personal competence |
| <input type="checkbox"/> Creative activities | <input type="checkbox"/> Perseverance |
| <input type="checkbox"/> Curiosity | <input type="checkbox"/> Positive peer influence |
| <input type="checkbox"/> Decision-making skills | <input type="checkbox"/> Reads for pleasure |
| <input type="checkbox"/> Family expectations:
<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low | <input type="checkbox"/> Responsibility |
| <input type="checkbox"/> Flexibility | <input type="checkbox"/> School achievement |
| <input type="checkbox"/> Future goals | <input type="checkbox"/> Self-control |
| <input type="checkbox"/> Honesty | <input type="checkbox"/> Self-motivation |
| <input type="checkbox"/> Involved in youth programs | <input type="checkbox"/> Sense of humor |
| <input type="checkbox"/> Independence | <input type="checkbox"/> Sense of self-worth |
| | <input type="checkbox"/> Shows effort |

Other Concerns or Strengths:

Current Services

After-school programs: _____

After-school sports: _____

Community clubs: _____

Gifted program: _____

Medication/s: _____

Special education: _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule

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.

I have read and understand the terms of this Notice. _____
Signature Date

I request a copy of this Notice. _____ I do not request a copy of this Notice. _____

This office is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice. If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- *A provider or assistant obtains treatment information about you and records it in a health record.*
- *During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will obtain your signed authorization before sharing information with such specialists to obtain his/her input.*
- *Referral information may be forwarded to Diagnostic Testing Labs for further treatment or testing where the provider will want results of such treatment or testing reported back to him/her.*
- *If the provider is a specialist, your health information and progress may be reported back to your primary care provider or referring provider, upon receipt of your written authorization.*

Example of use of your health information for payment purposes:

- *We submit requests for payment to your health insurance company. The health insurance company requests health information from us regarding medical care given. We will provide information to them about you and the care given. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used. A billing company, in compliance with all HIPPA requirements, will be used to process your insurance payment.*

Example of use of your health information for health care operations:

- *We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.*

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the treating provider. The information in it, however, belongs to you. You have the right to:

- *Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted as required by law;*
- *Obtain a paper copy of the Notice of Privacy Practices for Protected Health information ("Notice") by making a request at our office;*
- *Request that you be allowed to inspect and copy your billing record - you may exercise this right by delivering the request in writing to our office;*
- *Obtain an accounting of disclosures of your health information as required to be maintained by law, upon request. An accounting will not include internal uses of information for treatment, payment, operations, or disclosures made to you; and*

- *Revoke authorizations that you made previously to use or disclose information, except to the extent information or action has already been taken, by delivering a written revocation to our office.*

If you want to exercise any of the above rights, please contact Catherine E. Rosick at 10149 N. 92nd Street, Suite 103 Scottsdale, AZ 85258, in person or in writing, during normal business hours. She will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

OUR RESPONSIBILITIES

This office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact *Catherine E. Rosick at 602-576-4779*. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to 10149 N. 92nd Street, Suite 103 Scottsdale, AZ 85258. You may also file a complaint by mailing it to the Secretary of Health and Human Services.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. Likewise, we cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

OTHER DISCLOSURES AND USES

Notification of Family/Friends: Our office does NOT disclose protected health information or any other information to family members.

Appointment Reminders and Treatment Information: We may contact you and/or leave a message on your telephone answering machine to provide you with appointment reminders or billing information.

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers Compensation.

Abuse, Neglect & Domestic Violence: We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and safety or the health and safety of other individuals.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime in emergencies; and other appropriate situations as permitted by law.

Judicial/Administrative Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, discovery request, or other lawful process if certain specific requirements are met. To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Other Uses: Any other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Effective Date: November 1, 2005

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INFORMED CONSENT FOR TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask any questions that you may have during your session. Once you sign this, it will constitute a binding agreement between us.

CONFIDENTIALITY

Law protects the confidentiality of all counseling interactions. Unless you grant me written permission, I will neither inform anyone that you and/or your minor child/children are receiving counseling, nor will I disclose the content of any session. However, there are circumstances that impose on a client's 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.

_____ **Initial**

PROFESSIONAL FEES

My fee for each 50-minute session is \$120.00. Clients receiving counseling are expected to pay at the time services are rendered. Payment can be made by cash, check, or charge (MasterCard, Visa, and American Express). Clients who are using insurance are responsible for any co-pays, co-insurance, and yearly deductibles. Client telephone calls, consultations with other professionals, and report preparation of less than 15 minutes are conducted without charge. Those exceeding 15 minutes are billed at the 50-minute per session rate.

_____ **Initial**

CANCELLATIONS AND MISSED APPOINTMENTS

I understand that, at times, it may be necessary to cancel an appointment. To help me be most effective and responsible in the use of my time, I require that any changes or cancellations be made at least 24 hours before your scheduled appointment. Because your appointment time is held exclusively for you, any cancellations received less than 24 hours before your scheduled appointment will be charged \$50.00. Insurance does not cover cancellation fees for missed appointments.

_____ **Initial**

CLIENTS' RIGHT AND RESPONSIBILITIES

As the client, you have received a form in this packet explaining your rights and responsibilities. After reading this form, you may ask any questions needed to fully understand your rights and responsibilities. You can address any concerns or grievances with your therapist, Catherine E. Rosick, M.Ed., NCC, LPC. You may also contact the Board of Behavioral Health, the licensing board that regulates this therapist's professional practice.

_____ **Initial**

CONTACTING ME

As your therapist, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by an automated voice messaging system, which I monitor seven days a week. I will make every effort to return your call within 24 hours. If you are difficult to reach, please leave the times you will be available. If your situation is an emergency, please 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 this page 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 _____

(If client is a minor)

Date _____

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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)