Compassion Centered Therapy
FOR WOMEN LLC

Jeanine Austin Stotts, LCSW (CA and AZ)
AZ LCSW17608 and CA LCSW17890
info@CompassionCenteredTherapyforWomen.com | 480.501.0600

INFORMED CONSENT FOR PSYCHOTHERAPEUTIC BASED CLINICAL SERVICES

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 written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to Compassion Centered Therapy for Women LLC that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. 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 Compassion Centered Therapy for Women LLC. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Compassion Centered Therapy for Women LLC will use clinical judgment when revealing such information. Compassion Centered Therapy for Women LLC will not release records to any outside party unless authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where Compassion Centered Therapy for Women LLC becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, we will do whatever we can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, we may also contact the emergency contact person whose name you have provided on the biographical sheet.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct Compassion Centered Therapy for Women LLC, only the minimum necessary information will be communicated to the carrier. Compassion Centered Therapy for Women LLC has no control over, or knowledge of, what insurance companies do with the information s/he submits 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 capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the 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 hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

LITIGATION: Sometimes patients (or the opposing attorney, in a legal case) want the records disclosed to the legal system. Due to the nature of the psychotherapeutic process and the fact that it often involves making a full disclosure with regard to many matters, clients' records are generally confidential and private in nature. Compassion Centered Therapy for Women LLC reserves the right to refuse disclosure of such clinical documentation. However, you, as the client, have the right to review your own psychotherapy records anytime.

CONSULTATION: Compassion Centered Therapy for Women LLC consults regularly with other professionals regarding clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted email and texts communication (which are part of the clinical records) can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails and texts are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails and texts that go through them. While data on Compassion Centered Therapy for Women LLC's laptops are encrypted, emails and texts are not. It is always a possibility that texts and email can be sent erroneously to the wrong address and computers. Compassion Centered Therapy for Women LLC's laptops are equipped with a firewall, a virus protection and a password, and the practice backs up all confidential information from the computer on a regular basis onto an encrypted hard- drive. Please notify Compassion Centered Therapy for Women LLC if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, or phone messages. If you communicate confidential or private information via unencrypted email, texts or via phone messages, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, email, voice mail, or faxes for emergencies.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of Compassion Centered Therapy for Women LLC require that we keep treatment records for at least 7 years. Please note that clinically relevant information from emails and texts are part of the clinical records. Unless otherwise agreed to be necessary, Compassion Centered Therapy for Women LLC retains clinical records only as long as is mandated by Arizona and California State law. If you have concerns regarding the treatment records, please discuss them with Compassion Centered Therapy for Women LLC. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Compassion Centered Therapy for Women LLC assesses that releasing such information might be harmful in any way. In such a case, Compassion Centered Therapy for Women LLC will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, Compassion Centered Therapy for Women LLC will release information to any agency/person you specify unless Compassion Centered Therapy for Women LLC assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, Compassion Centered Therapy for Women LLC will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Compassion Centered Therapy for

Women LLC between sessions, please leave a message at the answering service 480.501.0600 and your call will be returned as soon as possible. Compassion Centered Therapy for Women LLC checks messages only on most weekends and Mondays except when we are on vacation. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call the 24-hour crisis line In Arizona **Mercy Maricopa Crisis Services: (800) 631-1314 or in California or Arizona please call 911.** Please do not use email for emergencies. Compassion Centered Therapy for Women LLC does not always check email daily.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $180 per 55 minutes at the end of each session, unless other arrangements have been made. Because we want to ensure that individuals have access to quality therapy services regardless of coverage, a sliding scale rate is offered for cash pay clients at $150 per 55 minute session. This rate must be preapproved by Compassion Centered Therapy for Women LLC. Telephone conversations, site visits, writing and reading of reports, 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 upon otherwise. Please notify Compassion Centered Therapy for Women LLC if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, Compassion Centered Therapy for Women LLC will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Compassion Centered Therapy for Women LLC can use legal or other means (courts, collection agencies, etc.) to obtain payment.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: 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. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Compassion Centered Therapy for Women LLC 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. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Compassion Centered Therapy for Women LLC may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance 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 Compassion Centered Therapy for Women LLC is likely to draw on various psychological approaches according, in part, to the problem that is being treated and assessment of what will best benefit you. These approaches include, but are not limited to: art therapy, play therapy. sand play therapy, Cognitive Behavior Therapy (CBT), hypnosis, Mindfulness-Based Cognitive Therapy (MBCT), personality measure psycho-education, Social Thinking (r) education, non-clinical mindfulness practice, and psycho-education training, Eye Movement Desensitization and Reprocessing (EMDR), Solution Focused Therapy, existential, developmental, humanistic or other psycho-educational training. Compassion Centered Therapy for Women LLC provides neither custody evaluation recommendation nor medication or prescription recommendation, nor legal advice, as these activities do not fall within our scope of practice.

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, Compassion Centered Therapy for Women LLC will discuss with you our working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, the possible risks, Compassion Centered Therapy for Women LLC's expertise in employing them, 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.

TERMINATION: As set forth above, after the first couple of meetings, Compassion Centered Therapy for Women LLC will assess if we can be of benefit to you. Compassion Centered Therapy for Women LLC does not work with clients who, in our opinion, we cannot help. In such a case, if appropriate, we will give you referrals that you can contact. If at any point during psychotherapeutic services, Compassion Centered Therapy for Women LLC either assesses that we are not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, we will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, we would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, Compassion Centered Therapy for Women LLC will talk to the 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, Compassion Centered Therapy for Women LLC will give you a couple of referrals that you may want to contact, and if we have your written consent, we will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, Compassion Centered Therapy for Women LLC will provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Compassion Centered Therapy for Women LLC's objectivity, clinical judgment or can be exploitative in nature. Compassion Centered Therapy for Women LLC will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, small communities, military bases, university campuses, spiritual and rehabilitation communities, etc., multiple relationships are either unavoidable or expected. Compassion Centered Therapy for Women LLC will never acknowledge working with anyone without his/her written permission. Many clients have chosen Compas-

sion Centered Therapy for Women LLC as their therapist because they knew him/her before they entered therapy with him/her, and/or are personally aware of his/her professional work and achievements. Nevertheless, Compassion Centered Therapy for Women LLC will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise Compassion Centered Therapy for Women LLC if the dual or multiple relationship becomes uncomfortable for you in any way. Compassion Centered Therapy for Women LLC will always listen carefully and respond to your feedback and will discontinue the dual relationship if we find it interfering with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

SOCIAL NETWORKING AND INTERNET SEARCHES: We do not accept friend requests from current or former clients on social networking sites, such as Facebook. We believe that adding clients as friends on these sites and/or communicating via such sites can compromise privacy and confidentiality. For this same reason, we request that clients not communicate with us via any interactive or social networking web sites.

AUDIO OR VIDEO RECORDING: Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by Compassion Centered Therapy for Women LLC.

CANCELLATION: Since the 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. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. For these purposes, we will make a copy (or notate the relevant information) of your current credit card and place this securely in your file. Please note, that this information will remain locked and is confidential. However, in the occurrence of missing a therapy session (and without prior notification of the absence), we charge your credit card for the previously addressed session fees and time.

GROUP THERAPY: In group therapy, it is of utmost importance that all members maintain confidentiality and disclose neither the content of sessions nor the identity of fellow group members. It is highly recommended that any meaningful exchange outside the group also be discussed in the group. In group therapy, the other members of the group are not therapists; therefore, they are not regulated by the same ethics and laws that bind the therapists. The limits of confidentiality and the reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality, you cannot be certain that they will always keep what you say in the group confidential. You are ultimately responsible for what you say and what you think, feel, or do with the feedback you receive in the group. Hence, it is important to approach outside relationships with other group members with caution. Group members are discouraged from forming relationships with one another during the course of group therapy for reasons including, but not limited to, confidentiality, influence, etc.

JEANINE MARIE AUSTIN STOTTS, LCSW has an LCSW (Licensed Clinical Social Work license) in both California and Arizona. Therapist works and lives predominately in Arizona. Therapy work in California will be on a very limited basis. Jeanine has a bachelor's degree and master's degree in clinical social work. Therapist earned a non-traditional doctorate in trans-personal life coaching in 2006 completing a dissertation on existential suffering. In her current capacity as therapist, therapist works under her clinical social work license and

does not use the "doctorate" designation in this current capacity. In the past when not holding a clinical social work license, therapist used the doctor designation and was clear online, on radio shows, in published works, earned certificates and audio recordings that she was a doctor of life coaching. Therapist no longer works as a life coach. Therapist is clear with clients that any past publications or public works using doctor, refers to the life coaching doctorate. Therapist is not a Ph.D in psychology or social work at this time.

I have read the above Office Policies and General Information, Agreement for Psychotherapy Services or Informed Consent for Psychotherapy carefully (a total of 6 pages); I understand them and agree to comply with them:

Client's Name ***(print)*** _____

Signature _____ **Date** _____

Guardian's Name ***(print)*** _____

Signature _____ **Date** _____

Compassion Centered Therapy for Women LLC ***(print)*** _____

Signature _____ **Date** _____

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PAYMENTS & INSURANCE REIMBURSEMENT

Compassion Centered Therapy for Women LLC is in network with Blue Cross Blue Shield of Arizona. Please complete this page only if you are covered under a BCBS policy. For all other insurance policies please refer to the billing agreement for information on requesting out of network reimbursement.

Your health insurance carrier will be billed the standard fee of $180.00 per 55 minutes at the end of each session. Please note it is the client's responsibility to be aware of behavioral health coverages under your specific insurance plan. This includes, but is not limited to, a baseline deductible that may need to be met prior to your insurance carrier covering costs for your behavioral health services, any co-pays due by you at the end of each therapy session, and any other relevant information needed to assist Compassion Centered Therapy for Women LLC with communicating with your insurance carrier.

Clients should be aware not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is rejected or unpaid by your insurance carrier for any reason, you will be held accountable and responsible for the full and/or remaining balance of therapeutic services rendered by Compassion Centered Therapy for Women LLC.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct Compassion Centered Therapy for Women LLC, only the minimum necessary information will be electronically communicated to the carrier. Compassion Centered Therapy for Women LLC has no control over, or knowledge of, what insurance companies do with the information submitted 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 capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the 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 hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies.

Please email a copy of your Blue Cross Blue Shields card separate from this welcome packet

Member ID: _____ **Group ID:** _____

Policy Holder Name: _____ **Policy Holder DOB:** _____

Copay: _____ **Deductible:** _____

Client's Name *(print)* _____

Signature _____ **Date** _____

Compassion Centered Therapy for Women LLC *(print)* _____

Signature _____ **Date** _____

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INFORMED CONSENT TO ASSUME RESPONSIBILITY FOR PAYMENT FOR PSYCHOTHERAPEUTIC SERVICES

I, _____ (client/guardian) agree to pay for psychotherapy services and other clinical services for _____ (client) according to the fee agreement between the therapist and the client. I understand the following terms apply to this agreement:

- The fee for psychotherapy, consultation, letter or report writing, or other clinical services is $180 per 55 minute session. Because we want to ensure that individuals have access to quality therapy services regardless of insurance coverage, a sliding scale rate is offered for cash pay clients at $150 per 55 minute session. All fees are due at time of service unless other arrangements have been made with Compassion Centered Therapy for Women LLC _____ (please initial).

- Because we understand that financial circumstances can change, please inform the therapist as soon as you know if there are changes in your ability or willingness to pay. Services will be terminated if timely payment is not made as agreed to by this consent. _____ (please initial).

- Consent to assume financial responsibility for these services does not entitle the third- party payer access to confidential information unless otherwise agreed in writing by the above-named client _____ (please initial).

- Upon your request and upon obtaining the client's written permission, if appropriate, you will be provided with a superbill, which is suitable for presenting to your insurance carrier for possible reimbursement. Not all conditions are reimbursable, and you will remain financially responsible for claims on services rendered regardless of reimbursement eligibility _____ (please initial).

- Per the informed consent, broken appointments where the therapist is not notified 24 hours or more in advance are subject to the full session fee. Compassion Centered Therapy for Women LLC holds an approved credit card on file and this fee will be charged automatically. Please complete this section fully. _____ (please initial).

Card Number: _____ Expiration Date: _____

Security code: _____ Billing Zip Code: _____

This agreement supplements previous informed consents *(please initial)*: _____

Signature of Client/Guardian: _____ Date: _____

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EMAIL AND ALTERNATIVE COMMUNICATION CONFIDENTIALITY

It is important to be aware that email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. It is important that you be aware that emails are part of the medical records. Un-encrypted emails are even more vulnerable to unauthorized access. As a result, Compassion Centered Therapy for Women LLC requires client consent before electronic communication can occur for clients who are currently engaged or have been engaged in the past with psychotherapy services through Compassion Centered Therapy for Women LLC. Please do not use email for emergencies. Phone messages and emails are checked frequently but may not be checked daily.

_____ *(Initial)* I give consent for Compassion Centered Therapy for Women LLC to correspond with me through electronic email exchange. The preferred email address is

_____

_____ *(Initial)* I give consent for Compassion Centered Therapy for Women LLC to correspond with me through text messaging. The preferred phone number for text messaging service is

_____

_____ *(Initial)* I give consent for Compassion Centered Therapy for Women LLC to leave a voicemail identifying themselves with general information including but not limited to appointment reminders, requesting a call back, and follow up on service requests. The preferred phone number for voicemails is

_____

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AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I authorize Compassion Centered Therapy for Women LLC to discuss (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation with any person/s or staff of clinic, office, agency, or institution/s named below and receive any relevant information from them.

1. _____
2. _____
3. _____
4. _____

For the following reason(s):

- ◯ Consultation/Psychotherapy
- ◯ Evaluation
- ◯ Other: _____

I may revoke this consent at any time. This consent is in effect for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the informed consent form (Form #1).

Name *(print)* _____ Date _____

Signature _____

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BIOGRAPHICAL INFORMATION – INTAKE FORM

Please fill out this biographical background form as completely as possible. It will help us in our work together. Information is confidential as outlined in the informed consent form and the HIPAA Notice of Privacy Practices. Please print or write clearly and either bring it with you to the first session OR email it prior to your session: info@CompassionCenteredTherapyforWomen.com

NAME: _____

GENDER: _____ DATE: _____

ETHNICITY/HERITAGE: _____

DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONES: H: _____ C: _____

PREFERRED COMMUNICATION *(please choose one or both):*

Phone _____ Email: _____

EMERGENCY CONTACT *(Name and phone number):* _____

REFERRAL SOURCE: _____

OCCUPATION *(former, if retired):* _____

PRESENTING PROBLEM *(be as specific as you can: when did it start, how does it affect you.):*

_____

_____

_____

_____

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BIOGRAPHICAL INFORMATION – INTAKE FORM CONT.

Estimate the severity of above problem: ◯ Mild ◯ Moderate ◯ Severe ◯ Very severe

CURRENT: Relationship status *(i.e. Single, Married, Separated, Divorced, etc.):* _____

PAST & PRESENT MARRIAGE/S *(names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):*

_____

_____

_____

CHILDREN/STEP/GRAND *(names/ages & brief statement on your relationship with the person.)*

1. _____

2. _____

3. _____

PARENTS/STEPPARENTS *(Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):*

Father: _____

_____

_____

Mother: _____

_____

_____

Stepparents: _____

_____

_____

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BIOGRAPHICAL INFORMATION – INTAKE FORM CONT.

SIBLINGS *(name/age, if deceased: age and cause of death and brief statement about the relationship.):*

1. _____

2. _____

3. _____

Medical Doctor/Psychiartrist Name/Psychiatrist history *(please include all):* _____

_____

PAST/PRESENT MEDICAL CARE *(major medical problems, surgeries, accidents, falls, illness, etc.):*

_____

_____

_____

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

_____

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE *(AA, NA, treatments):*

_____

_____

_____

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BIOGRAPHICAL INFORMATION – INTAKE FORM CONT.

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR *(describe: ages, reasons, circumstances, how, etc.)*

FAMILY MEDICAL HISTORY *(Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):*

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

PAST/PRESENT PSYCHOTHERAPY *(specify: month year(s) (beginning—end), estimated number of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):*

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BIOGRAPHICAL INFORMATION – INTAKE FORM CONT.

DESCRIBE YOUR CHILDHOOD, IN GENERAL *(Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):*

IF PARENTS DIVORCED: Your age at the time: _____. Describe how it affected you at the time

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE *(including suicide, depression, hospitalizations in mental institutions, abuse, etc.):*

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? *(if you answer Yes, please explain):*

What gives you the most joy or pleasure in your life? _____

What are your main worries and fears? _____

What are your most important hopes or dreams? _____

Do you work or attend school? _____

Can you write a little about how many hours and the nature of your work &/or schooling and where?

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DIRECTIVE TO PROTECT MENTAL HEALTH INFORMATION
[States other than CA version]

I hereby appoint *Jeanine Austin Stotts, MSW, LCSW* as custodian of my mental health records after my death. This Directive refers to confidential records created while under his/her care. I authorize Jeanine Austin Stotts, LCSW to refuse to disclose any Protected Health Information under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other confidential medical records, as define in AZ and CA state law, whether now existing or hereafter created, related to my mental health.

Such Protected Health Information or mental health records shall not be provided to my spouse, my lineal ancestors or descendants, my Personal Representative, my Personal Representative's respective attorneys, any court, attorney, licensing board, coroner's office or medical examiner personnel, other governmental, state or other agency, or any other persons or entities.

If I have authorized someone to receive my Protected Health Information under the Standards for Privacy of Individually Identifiable Health Care Information under HIPAA, or other state's laws, such authorization shall not apply to *Jeanine Austin Stotts, MSW, LCSW.*

Client's Name _____

Signature _____ Date _____

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SUPERBILL

NAME: _____ DATE: _____

FEE: _____ PREVIOUS BALANCE: _____ BALANCE DUE: _____

PAYMENT: _____ REMAINING BALANCE: _____

PLACE OF SERVICE: ◯ Office ◯ Hospital ◯ Other: _____

Date of Service:

CODE	SERVICE	FEE
90791	Diagnostic Evaluation	_____
90832	Individual Psychotherapy *(30 mins)*	_____
90834	Individual Psychotherapy *(45 mins)*	_____
90837	Individual Psychotherapy *(60 mins)*	_____
96100	Psych Testing *(per hr)*	_____
90846	Family Psychotherapy *(without client present)*	_____
90847	Family Psychotherapy *(with client present)*	_____
90848	Couples Therapy	_____
90853	Group Psychotherapy	_____
90885	Evaluation of Records	_____
90882	Case Management	_____
90887	Explanation of Evaluation to Family	_____
90889	Preparation of Report	_____
98910	Conference with Team *(30 mins)*	_____
98912	Conference with Team *(60 mins)*	_____
98920	Telephone Consultation *(Brief)*	_____
98922	Telephone Consultation	_____

DIAGNOSIS CODE: _____ THERAPIST'S SIGNATURE _____

AUTHORIZATION TO PAY BENEFITS TO LICENSED CLINICAL SOCIAL WORKER: I hereby authorize payment directly to the undersigned Licensed Clinical Social Worker of the Medical Benefits, if any, otherwise payable to me for his/her services as described below but not to exceed the reasonable and customary charge for these services.

Signed (Insured Person): _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Licensed Clinical Social Worker to release any information acquired in the course of my examination or treatment.

Signed (Client or Parent, if Minor): _____ Date: _____

Compassion Centered Therapy
FOR WOMEN LLC

Jeanine Austin Stotts, LCSW (CA and AZ)
AZ LCSW17608 and CA LCSW17890
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INFORMED CONSENT FOR VISITOR TO ATTEND PSYCHOTHERAPY OR CONSULTATION SESSION

I (client's name), _____, understand that if I choose to invite a person or persons to be present during a session with my therapist or consultant that my confidentiality may be compromised. I do so with the understanding that my therapist will use his/her clinical discretion when he/she chooses to share or reveal confidential and/or sensitive information. I understand that my therapist will use his or her clinical discretion and reasoning in sharing any information. I also understand that this may be upsetting or uncomfortable to me. Unless specified in writing, this consent does not give permission to the therapist to discuss any confidential information with the visitor any time after the visit.

I have clarified with my therapist that the following topics should NOT be mentioned or discussed during the time that the visitor comes to the session:

_____

_____

_____

This agreement supplements prior informed consents.

Client Name *(print)* _____ Date _____

Signature _____

Witness Name *(print)* _____ Date _____

Signature _____

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TELEHEALTH DISCLOSURE
Telemedicine Informed Consent

I ,_____, hereby consent to engage in telemedicine (e.g., internet or telephone based therapy) with Jeanine Austin Stotts, LCSW Licensed Clinical Social Worker as the main venue for my therapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communication. I understand that telemedicine also involves the communication of my medical/mental health information, both verbally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences of telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine based services and care may not yield the same results nor be as comprehensive as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face service), I will be referred to a therapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my therapist, my condition may not

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TELEHEALTH DISCLOSURE
Telemedicine Informed Consent Cont.

improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with California or Arizona State Law law, that these services may not be covered by insurance, and that if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.

Client Name *(print)* _____ Date _____

Signature _____

Witness Name *(print)* _____ Date _____

Signature _____

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E-MAIL SIGNATURE REGARDING CONFIDENTIALITY

Notice of Confidentiality: This e-mail, and any attachments, are intended only for use by the addressee(s) and may contain privileged, private or confidential information. Any distribution, reading, copying, or use of this communication and any attachments, by anyone other than the addressee, is strictly prohibited and may be unlawful. If you have received this e-mail in error, please immediately notify me by e-mail (by replying to this message) or telephone 480.510.0600 and permanently destroy or delete the original email, any copy or print-out of this e-mail, and any attachments.

It is important to be aware that e-mail communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. 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. Un-encrypted e-mails, such as this, are even more vulnerable to unauthorized access. Please notify Jeanine Austin Stotts, LCSW Licensed Clinical Social Worker if you decide to avoid or limit in any way the use of e-mail. Phone (call and text) and email messages are checked on Saturday, Sunday and Monday except when on vacation.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Fax: _____

E-Mail: _____

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CONSENT FOR TREATMENT FOR MINOR(S) AND OTHERS

I, (*name of individual)* _____

give my consent that *(Jeanine Austin Stotts, LCSW)* _____

will be conducting therapy with *(name of minor)* _____

My relationship to the client *(parent, uncle, etc.):* _____

I was notified that the holder of the privilege is *(parent, guardian, etc.):*

(name) _____ *(relationship)* _____

I was also notified that all material discussed during the therapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitations to confidentiality in the Office Policies form, which I have read and signed.

In case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Jeanine Austin Stotts therapist's judgment in regard to releasing or sharing information obtained during the course of therapy with the minor that may endanger or jeopardize the patient's well being.

My signature below grants my consent to the above.

Name *(print)* _____ Date _____

Relationship _____

Name *(print)* _____ Date _____

Relationship _____

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CONSENT TO PHOTOGRAPH ARTWORK

I, _____, hereby authorize Compassion Centered Therapy for Women LLC to take photographs of my artwork. I understand that the intentions of these photographs are for therapeutic processing purposes and my rights to privacy and confidentiality will not be surrendered by granting permission for photographs and documentation of my artwork to be taken. I understand if the artwork is to be displayed or used for clinical outreach purposes, that my name and identifying information will remain anonymous and be protected by Compassion Centered Therapy for Women LLC. I understand that this consent is voluntary and whether I choose for my artwork to be photographed, will not affect my relationship with or services rendered by Compassion Centered Therapy for Women, LLC.

I have read the above, have understood it, and agree to the terms.

Name *(print)* _____ Date _____

Signature _____

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Consent to Use Telehealth for Psychotherapy For COVID-19 Social Distancing

"Telehealth" or "teletherapy" is designed to be the mode of delivering health care services (psychotherapy) via information and communication technologies (e.g. phone or internet) to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site (where you are currently residing) and the health care provider is at a distant site (where the therapist is residing).

Considerations Regarding Telehealth:

• The connection may not be stable. Video can freeze, audio can be dropped, the connection may go black, and if you are in a state of crisis (considering self-harm or suicide), losing the connection would be very bad. A wired connection to your mobile device is ideal, but if you must go wireless, it should be a very strong connection. The therapist can terminate a telehealth session if it is determined that a stable telecommunication connection cannot be adequately maintained.

• Your computer may have problems that preclude a telehealth session. You are strongly encouraged to make sure you have the latest operating system and security updates, including installation of current and up-to- date antivirus and internet security software, installed on the computer or smartphone you want to use for telehealth sessions. Again, the therapist can terminate a telehealth session if it is determined that a stable telecommunication connection cannot be adequately maintained.

• The session may not be secure or confidential unless you make it so. The therapist will be in a private office for your security and confidentiality, so it is encouraged that you locate yourself in a place that you know is private and secure. Therefore, initiating a session at the beach, a park, Denny's, or Starbucks is neither private, confidential, nor secure.

• Crisis support services may not be available where you are currently residing or in your geographic area. If you are in a state of crisis and you have no place to get help, there is little a therapist can do from across the wire. The therapist is responsible for identifying resources in your area based on your address (assuming you have one), but it is entirely up to you to access and utilize those resources.

• There is a lot a therapist CANNOT see during a telehealth session. From a tiny, fifteen-inch, two-dimensional image, there is significant information that a therapist can miss. Noteworthy mannerisms, gestures, body language or expression, physical appearance, grooming, appropriateness of dress are just a few marks of data that can be missed in a telehealth session.
This information could be very helpful to your progress in treatment.

I have read consent to using telehealth as a mode of psychotherapy and mental health treatment.

Signature of client or guardian consent for minor Date