

Desert Vista Counseling Services, L.L.C.

Mesa Location

2929 N. Power Rd. Suite 101
Mesa, Arizona 85215
Ph: 602-550-9393
Fax: 623-565-8016

www.desertvistacounseling.com

Scottsdale Location

7403 E. 6th Ave., Suite 5
Scottsdale, AZ 85251
Ph: 480-946-3082
Fax: 480-947-3778

Office Policies and Statement of Informed Consent

Objectives of Counseling:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting psychological healing and emotional well-being.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s). You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

Risks of Therapy:

The therapeutic process can be a very emotional experience. It is common to experience uncomfortable emotions such as sadness, fear, or frustration during the course of your therapy. These emotions can vary in degree, depending on the nature of your difficulty. While your therapist can not remove these feelings for you, they will help you work through them. In most cases these feelings are a normal part of the growth process. It is important that you take the responsibility to discuss any discomfort you feel with your therapist.

Appointments:

Appointments are usually scheduled for 45 minutes. Longer appointments can be scheduled according to the client(s)' needs. Clients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time.

Fees:

Payment is due at the time of service. The Dr. Gold's fee for services is **\$135.00 for a 45-minute session**. Please be advised that you are billed based on the duration of the session and that longer sessions, therefore, will be billed at the same rate of \$135 per 45 minutes (e.g., 1 hour = \$180, 1 ½ hours = \$270). The fee for all other therapists (unlicensed therapists being directly supervised by Dr. Gold) is \$110 per session.

If you have no out-of-network insurance benefits, all therapists, including Dr. Gold, have a sliding fee scale.

If you have out-of-network benefits, your insurance may reimburse you for a portion of this fee. If you do have this type of coverage, you must still pay at the time of service and you will be responsible for pursuing any reimbursement from your insurance. Upon request, Dr. Gold will provide you with a receipt for services for you to submit to your insurance. If you have no insurance coverage at all, Dr. Gold does have a sliding fee scale based on family size & income. You may pay with cash, check, or credit card.

You may pay with cash, credit or debit card (Visa, Master Card, & Discover). **Upon scheduling your first appointment, you will be required to give your credit card information and agree to authorize Dr. Gold to charge that card for your sessions in the event that other payment has not been made at the time of service, or in the event of late cancellation or missed session that was not cancelled prior to 24 hr notice.**

Phone Contact is billed at the same rate as face-to-face sessions. There is no charge for phone calls lasting 10 minutes or less.

Client's Initials _____

Cancellations and Missed Appointments:

Please be aware that you may leave a message to cancel your appointment 24hrs a day. As long as you cancel your appointment at least 24-hours in advance from the time your appointment was scheduled, you will not be charged. However, **you will be billed the full session fee of \$135 for any cancellations made in less than 24 hours prior to your scheduled appointment** . Please be aware that insurance generally does not reimburse clients for missed or late-cancelled appointments.

Unpaid Balances:

Please be aware that **your therapist will be unable to continue seeing you for scheduled sessions once you accrue an overdue balance of \$250 or more, or if you no-show three consecutive sessions**. Your file will be closed and a letter notifying you of this will be sent to the address listed on your intake paperwork.

Emergencies:

If the emergency is life threatening (dangerous to you or anyone else) CALL 911. If it is a non-life threatening emergency, you may call your therapist and she will speak with you by phone and/or schedule an emergency session with you if you need her to. If you are unable to reach your therapist, you may call your primary care physician, the local emergency room, or the crisis hotline: **EMPACT 480-784-1500**

Record Keeping:

A clinical chart is maintained describing your condition, your treatment, progress in treatment, dates & fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section of this document. Your records are stored in a secured manner to protect your confidentiality. You may receive a copy of your records if you make a formal written request to Dr. Gold, the clinical director of Desert Vista Counseling Services, L.L.C., and pay a \$75 retrieval fee. Please be advised that it may take up to 30-days to receive your records from the day your request is received. If your therapist determines it would not clinically be in the client's best interest to receive the complete records, a summary of the notes will be provided instead.

Treatment of Minors:

Desert Vista Counseling Services does provide counseling to minors, defined to be individuals under the age of 18. If a parent/legal guardian is bringing the child in for services, the **written consent of both parents** or legal guardians is required except as otherwise determined by law. Additional documentation of guardianship might need to be provided in certain circumstances, such as divorce, before treatment can begin.

Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child
2. Sexual activity between a minor and any person age 18 years or older
3. When your psychiatrist or therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself.
4. If you report that you intend to physically injure someone.
5. If your therapist is ordered by a court to release information as part of a legal involvement.
6. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
7. In natural disasters whereby protected records may become exposed.
8. When otherwise required by law.

In the event that you would like your therapist to speak with other health professionals or to family members, you will be required to complete a Release of Information form in order for them to do so.

In the event that you disclose to your therapist that you or someone you know is abusing a child or there exists sexual activity between a minor and any person age 18 or older, they are required by law to make a report to either Arizona Child Protective Services or the police.

In the event that you disclose information to your therapist that leads her to believe that you are a danger to yourself or others and you are unwilling to voluntarily admit yourself to inpatient care (hospital or other treatment facility), your therapist is required to contact a psychiatric facility or hospital to file the appropriate papers for an involuntary admission for treatment. This is to ensure safety for yourself and others and ensure you receive appropriate medical treatment.

Client's Initials _____

Confidentiality Continued:

In the event that you disclose to your therapist that you are a danger to others, they are required by law to report you to the police and potential victim(s).

THERE WILL BE NO EXCEPTIONS MADE TO THESE POLICIES, AS THEY ARE MANDATED BY LAW.

Scope of Practice:

The therapists at Desert Vista Counseling Services have limited availability. They are not on-call, nor do they have an emergency staff for after-hours treatment. Persons who may be in need of immediate care, or are frequently in crisis, will need more availability than the therapists at Desert Vista Counseling Services are able to provide. Certain conditions and diagnosis are also not within the scope of these therapists’ expertise (e.g., severe mental illness). Given the nature and scope of their practice, the therapists at Desert Vista Counseling reserve the right not to treat persons with certain diagnoses or treatment histories, such as those listed below. They will, however, assist you by referring to professionals that can better serve your treatment needs.

- Any Severe Mental Illness: (including but not limited to Schizophrenia, and Disassociative Identity Disorder)
- Anti-Social, Paranoid, Schizotypal or Dependent Personality Disorders
- Impulse Control Disorders (Intermittent Explosive Disorder, Kleptomania, Pyromania, Trichotillomania)
- Any persons who have ever committed sexual or physical assault (whether or not you were convicted)

The following circumstances will also warrant termination of services based on the therapist’s assessment of the client’s treatment needs and if it is in the client’s best interest to receive a higher level of care and/or more highly specialized treatment:

- * **Failure to disclose History of Prior Hospitalization** or in-patient treatment for mental health issues (e.g., suicide attempt, eating disorder, substance abuse).
- ***Failure to Disclose Ongoing Substance Abuse**
- ***Current Involvement with any Illegal Activity**

By signing this agreement, you are stating that you have never been diagnosed with any of the disorders listed as being outside the scope of practice (the above list) and that you have never been hospitalized or participated in in-patient treatment at any time in your life.

Client-Therapist Boundaries:

The client-therapist relationship is a professional relationship with ethical rules governing its parameters. According to the AZ Board of Behavioral Health, it is an ethical violation for your therapist to accept or receive gifts or to establish any relationship with a client, besides that of client/therapist, even after you have completed your therapy. Your therapist is therefore unable to attend weddings, funerals, parties, or meet with clients outside of therapy for any reason. Please know that their refusal to do so is not out of insensitivity or ingratitude, but out of a desire to maintain appropriate professional boundaries with clients. Once you have entered into a client/therapist relationship, the relationship will be limited to these roles even after you have completed your treatment

Consent for Treatment

By signing below, you are stating that:

- 1) You have read and understood this 3-page (including this page) policy statement.
- 2) You have had your questions answered to your satisfaction.

I accept, understand, and agree to abide by the contents and terms of this agreement. Further, I consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time

Client’s Printed Name: _____

Client’s Signature: _____
(Or GUARDIAN if client is a minor)

Date: _____

Therapist’s Signature: _____

Date: _____