Kathy Infeld, MSNc,PMHCNS-BC

9929 N. 95th Street, Suite 101 • Scottsdale, AZ 85258 • (480) 948-2631

Patient's Full Name: _____SSN: _____
Date of Birth: _____ Referred by:_____

Information Pertaining to Person Financially Responsible

Full Name (Guardian or Insured):_____SSN:_____ Birthdate:_____

Address:_____ City/State: _____ Zip:_____

Home Phone: _____ Work Phone: _____

Present employer: _____

Employer's address:_____

Office Policy and Financial Responsibility Statement

I UNDERSTAND THAT:Couple sessions initially are 70 minutes in length and $250.00. for the first session. Subsequent sessions are $200.00 an hour.

- **Individual Sessions are 45-50 minutes in length and are billed at $200.00per session.**
- **Sessions of late arrivals will end on time.**
- **The rate of $200.00 per hour will also apply to time spent providing special services, such as telephone sessions, phone calls, document reviews, or case consultations, as well as time spent discussing treatment with other authorized professionals.**
- **Payment of cash or check is expected at the end of each session unless other arrangements have been made.**
- **Kathy does not accept insurance. By signing this form, I am agreeing to pay the entire bill at the time of service. If requested, I can obtain a "super bill" as a receipt to submit to a third party payer.**
- **Overdue accounts will be submitted to a collection agency and I will be responsible for any additional fees incurred by the collection agency.**
- **I will be billed $25.00 for all returned checks.**
- **I must give 24 hour notice of appointment cancellation or I will be billed IN FULL.**
- **I may obtain a copy of my records (or my minor child's records) with at least a 21 day advance written request. Copying and clerical fees will be assessed and must be paid prior to release of the records.**

I understand that I am financially responsible for any and all charges incurred for the treatment of the above-named.

I have read the above office policy regarding length of sessions, late arrivals, charges, returned checks, etc. **I agree to the stated terms.**

_____ _____

Signature of Client (or Parent of Minor child) Date

Signature of Client (or Parent of Minor child) Date

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Consent For Treatment

Please identify and complete the following for:

_____ Individual therapy
_____ Couple or Family therapy
_____ Minor or individual with a guardian

I welcome you as a new client, and look forward to working with you. The purpose of this form is to let you know about my approach to counseling and what you can expect from counseling. This form will also give you an opportunity to give consent for counseling.

In my view, the relationship of feelings and thoughts to behavior is crucial to understanding the issues that affect being successful in life. I use a variety of strategies to help people make positive strides in dealing with their life challenges, strategies that are mostly cognitive-behavioral in nature. That is, they are strategies based on the notion that the way people see themselves and the world influences how they feel and behave.

Individual counseling offers you a chance to express ideas and concerns to better understand your situation and to learn new ways to solve problems. However, there are risks to it. At times, you might experience feelings that are uncomfortable and hard to face. I always compare this process to taking cough medicine: it may not taste great, but it might be good for you in the long run. I will do my best to provide an accurate and fair assessment (i.e., diagnosis) that will help guide our treatment-planning (i.e., goal-setting). We can also discuss this assessment/diagnosis and your resulting treatment plan/goals throughout the counseling process.

Everything you discuss with me will be kept confidential except for matters pertaining to (1) harm to self or to another person, (2) physical/sexual abuse or neglect of minors, persons with disabilities, and the elderly, (3) legal activity resulting in a court order, (4) anything else required by law, (5) upon your request provided that you sign my Release of Information form. For these matters, legally and/or ethically, I would have to break confidentiality and involve others.

I/We _____ understand the information regarding confidentiality (stated on the Office Policy and Financial Responsibility Statement) and hereby consent to receive counseling services from Kathy Infeld, M.S., R.N., C.S.

_____ _____

Signature Date Signature of second person Date

Minor or Individual With A Guardian

I, the parent or guardian of _____ understand the information regarding confidentiality (stated on the Office Policy and Financial Responsibility Statement) and hereby consent to have Kathy Infeld, M.S., R.N., C.S. provide counseling for him/her/them.

_____ _____

Signature of parent/guardian Date Signature of parent/guardian, if present Date

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Client Psychosocial History and Status

Name: _____ Birthdate: _____ Age: _____

Address:_____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Briefly describe your reason for seeking help: _____

_____

_____

Who suggested you contact us ? _____

What is your religious affiliation?_____ None ❑

Education/Degrees: _____

Occupation: _____How Long? _____

Place of Employment: _____How Long? _____

Address:_____ City/State: _____ Zip: _____

If not employed, how long has it been since you worked? _____

What kind of job did you have? _____

What caused you to stop working? _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Living Together

Marriages/Significant Relationships

To Whom	*Length of Relationship*	*Termination of Relationship (if applicable)*	*Children from that Relationship (if any)*

If married, separated or living together, briefly describe your relationship:_____

_____

Age of spouse:_____ Religion: _____

Education, degrees? _____ Occupation: _____

Is he/she currently employed? ❑ Yes ❑ No How Long? _____

Has your spouse been previously married? ❑ Yes ❑ No Number of times: _____

How long since his/her last marriage? _____

Number of children from previous marriages: _____ Ages of children: _____

Extended Family: Parents, Siblings, And Others Close To You

Name	Relationship	Age	Occupation	Problems Alcohol/Mental/Emotional

How was it to grow up in your family?_____

_____

_____

With whom are you currently living?

Name	Relationship	Age	Use of Alcohol/Drugs	How do you get along?

Medical Information

When were you last examined by a physician? _____ Name of Doctor: _____

List any health problems for which you currently receive treatment:_____

_____

List any past health problems including accidents:_____

_____

List any medications you currently take: _____

Women only:

How many pregnancies have you had?_____Are you pregnant now? ❑ Yes ❑ No

Any miscarriages or abortions? ❑ Yes ❑ No How many? _____

Any changes in your menstrual cycle? _____

Men and women:

Are you sexually active? ❑ Yes ❑ No Beginning at what age? _____

Do you use birth control methods? ❑ Yes ❑ No If yes, what? _____

Have you ever had concern about eating habits? ❑ Yes ❑ No

Psychological/Emotional Information

Have you ever sought help or been treated for psychological or emotional reasons? ❑ Yes ❑ No

If so, when and where? _____

Have you ever thought about suicide? ❑ Yes ❑ No If so, did you have a plan? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No If so, how many times? _____

Alcohol/drug use history

Do you feel you have a drug or alcohol problem? ❑ Yes ❑ No

Have you ever had any previous treatment for drug / alcohol abuse? ❑ Yes ❑ No

If so, when and where? _____

List all drugs, including alcohol, that you currently use, or have used in the last year (indicate frequency and amount): _____

_____

Legal

Please list and describe any arrests or legal problems (including driving violations): _____

_____

_____

Circle any problem that pertains to you at the present:

Nervousness	Relaxation	Making Decisions	Stress
Shyness	Legal Matters	Self Control	Memory
Separation	Energy	Inferiority	Appetite
Drug Use	Loneliness	Bowel Troubles	Marriage
Anger	Education	Sexual Problems	Work
Sleep	Undereating	Alcohol Use	Overeating
Friends	Concentration	Nightmares	Temper
Fatigue	Ambition	Stomach Problems	Divorce
My thoughts	Parenthood	Health Problems	Age
Finances	My Appearance	Suicidal Thoughts	Future
Sexual Abuse	Children	Career Choices	Weight
Unhappiness	Depression	Headaches	Fears
Self-esteem	Sexual Orientation	Physical Abuse	

Circle everything that has happened to you in the past three years:

Death of a spouse/partner	Marriage Problems	Changes in marital status
Death of another family member	Family Problems (Children, in-laws)	Loss of Job
Major illness or injury–yourself	Financial Problems	Move to another city or state
Major illness or injury–family member	Legal Problems	Other: _____

Please list any additional information that you feel may be helpful: _____

_____