



CONSENT FOR EVALUATION AND TREATMENT

I hereby certify that I, being of sound mind and judgment, have read and understood the above treatment terms and contract (pages 1-4). I give my consent to be evaluated and treated by the treatment provider identified below. I understand that either party may discontinue this treatment contract at any time. I also agree to the release of protected health information (PHI) for the purposes of payment in the event where a third party payor is involved.

Client Signature (Parent or Guardian if Minor)

Cesar G. Gallegos Gamez, MA, LPC (Provider)

Today's Date

NOTICE OF HIPAA POLICIES AND PRACTICES

I ACKNOWLEDGE RECEIPT OF THE HIPAA PRIVACY RULES. I have received notice from my health care provider with North Phoenix Counseling, LLC, regarding his policies and practices to protect the privacy of my protected health information (PHI). I agree to read this document and to ask my treatment provider any questions that I have regarding his policies at our next session. If I do not ask questions, it will be understood that I am fully aware of the uses and disclosures of my protected health information (PHI) and my rights under HIPAA.

Client Signature (Parent or Guardian if Minor)

Cesar G. Gallegos Gamez, MA, LPC (Provider)

Today's Date



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RELEASE FORM FOR CHILDREN AND ADOLESCENTS

I, _____, legal Parent/Guardian give permission for

(name of client) _____ to be seen in counseling by Cesar G. Gallegos Gamez, MA, LPC either individually, in group therapy or as participant in a family therapy approach to treatment.

Today's date: _____

Signature of Parent/Guardian

Cesar G. Gallegos Gamez, MA, LPC
Provider



Release of Information and Coordination of Care between Health Care Providers

Communication between behavioral providers and your primary care physician (PCP), and other behavioral health providers is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This PHI may include diagnosis, treatment plan and/or progress.

Client Rights

- You may end this authorization at any time in writing by sending a notification to North Phoenix Counseling, LLC at the address listed on the top of this form.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- Unless court ordered, if you choose not to agree with this request, your benefits, treatment, or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing.

It is understood that after my information is disclosed to another person or company, it may not be protected by the federal privacy rule, could possibly be relayed to someone else, and may no longer be protected by federal HIPAA privacy regulations. **This consent expires in twelve (12) months from the date of my signature below unless otherwise stated.**

North Phoenix Counseling, LLC is authorized to release protected health information related to the evaluation and

treatment of _____ / _____ / _____
 (Client Name) (Date of Birth – MM/DD/YYYY)

May we coordinate care with your Primary Care Provider (PCP)? Yes No

PCP Name: _____ Company: _____

PCP Phone: _____ PCP Fax: _____

May we coordinate care with your previous or additional Behavioral Health provider ? Yes No

BH Provider Name/ Company: _____ Company: _____

PCP Phone: _____ PCP Fax: _____

May we coordinate care with any others you would like involved in your treatment? (family, friends, clergy, etc.) Yes No

Other Name: _____ Phone: _____

Other Name: _____ Phone: _____

Disclosure may include the following verbal or written information: (check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Face sheet | <input type="checkbox"/> History & physical | <input type="checkbox"/> Laboratory/diagnostic testing results | <input type="checkbox"/> School information |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Medication records | <input type="checkbox"/> Behavioral health/psychological consult | <input type="checkbox"/> Psychological eval/testing results |
| <input type="checkbox"/> ER record report | <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Summary of Treatment Records | <input type="checkbox"/> Custody Reports |
| <input type="checkbox"/> Substance abuse record | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Other |

 (Signature of Patient, Parent, Guardian or Authorized Representative)

 (Date)

CURRENT PSYCHAITRIC SYMPTOMS: CHECK THE CORRESPONDING BOX

ANXIOUS		AUDITORY HALLUCINATIONS		GUILT
HOPELESS		VISUAL HALLUCINATIONS		GRIEF
PARANOIA		OLFACTORY HALLUCINATIONS		PANIC ATTACKS
CONCENTRATION PROBLEMS		TACTILE (TOUCH) HALLUCINATIONS		MANIA
DEPRESSED MOOD		GUSTATORY (TASTE) HALLUCINATIONS		BEHAVIORAL PROBLEMS
DECREASED ENERGY		DELUSIONS (BIZARRE THOUGHTS)		TEARFULNESS
IMPULSIVITY		LOSING LAPSES OF TIME		WORRY
IRRITABILITY		HYPERACTIVITY		WEIGHT GAIN
INAPPROPRIATE ANGER		DISSOCIATION (OUT OF BODY)		WORTHLESSNESS
SELF-INJURIOUS BEHAVIOR		INAPPROPRIATE EUPHORIA		WEIGHT LOSS
MEMORY PROBLEMS		OBSESSION/COMPULSIONS		TOO MUCH SLEEP
DECREASED / NO INTEREST IN SEX		SOMATIC COMPLAINTS (EX. PAIN)		
DECREASED SLEEP		DISTURBED SLEEP		

THOUGHTS OF WANTING TO DIE? YES NO

IF YES, EXPLAIN WHY:

DO YOU HAVE A SUICIDAL PLAN TO HURT YOURSELF? YES NO

IF YES, EXPLAIN HOW YOU WOULD DO THIS:

DO YOU HAVE A HOMICIDAL PLAN TO HURT SOMEONE ELSE? YES NO

IF YES, EXPLAIN WHO YOU WOULD HURT AND HOW:

CHECK THE BOX IF YOU HAVE A **FAMILY HISTORY** OF THE FOLLOWING:

<input type="checkbox"/>	HYPERTENSION	<input type="checkbox"/>	KIDNEY DISEASE
<input type="checkbox"/>	HIGH CHOLESTEROL	<input type="checkbox"/>	RESPIRATORY DISEASE
<input type="checkbox"/>	CANCER	<input type="checkbox"/>	THYROID DISORDERS
<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	STROKE

CHECK THE BOX IF YOU HAVE A **PERSONAL HISTORY** OF ANY OF THE FOLLOWING:

<input type="checkbox"/>	HYPERTENSION	<input type="checkbox"/>	KIDNEY DISEASE
<input type="checkbox"/>	HIGH CHOLESTEROL	<input type="checkbox"/>	RESPIRATORY DISEASE
<input type="checkbox"/>	CANCER	<input type="checkbox"/>	THYROID DISORDERS
<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	GASTRIC DISORDERS
<input type="checkbox"/>	MAJOR HOSPITALIZATIONS	<input type="checkbox"/>	

CHECK THE BOX IF YOU HAVE A **FAMILY PSYCHIATRIC HISTORY** OF THE FOLLOWING:

<input type="checkbox"/>	DEPRESSION	<input type="checkbox"/>	BIPOLAR DISORDER
<input type="checkbox"/>	ADHD	<input type="checkbox"/>	ANXIETY
<input type="checkbox"/>	SCHIZOPHRENIA	<input type="checkbox"/>	SUICIDE ATTEMPTS
<input type="checkbox"/>	SUBSTANCE ABUSE/ALCOHOL ABUSE	<input type="checkbox"/>	OTHER:
<input type="checkbox"/>	MAJOR HOSPITALIZATIONS		

CHECK THE BOX IF YOU HAVE A **PERSONAL PSYCHIATRIC HISTORY** OF THE FOLLOWING:

<input type="checkbox"/>	DEPRESSION	<input type="checkbox"/>	BIPOLAR DISORDER
<input type="checkbox"/>	ADHD	<input type="checkbox"/>	ANXIETY
<input type="checkbox"/>	SCHIZOPHRENIA	<input type="checkbox"/>	SUICIDE ATTEMPTS
<input type="checkbox"/>	MAJOR HOSPITALIZATIONS: (LIST)	<input type="checkbox"/>	SUBSTANCE ABUSE/ALCOHOL ABUSE
		<input type="checkbox"/>	Type:
		<input type="checkbox"/>	First Use:
		<input type="checkbox"/>	Most Recent Use:
		<input type="checkbox"/>	Frequency:



Child/ Adolescent Developmental History

Date of Birth: _____

Date: _____

What was your child's birth weight?

_____ lbs. _____ oz. Unknown

Was delivery normal?

Yes Unknown

No; specify _____

Did the birth mother experience any physical or emotional problems during pregnancy?

Yes; specify _____

No Unknown

Were medications taken during pregnancy?

Yes; specify _____

No Unknown

Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?

Yes; specify _____

No Unknown

Did the baby experience any problems immediately after birth?

Yes; specify _____

No Unknown

Has your child ever required hospitalization?

Yes; specify _____

No Unknown

Is there any history of physical, sexual or emotional abuse?

Yes; specify _____

No Unknown

Is there a history of prolonged separations or traumatic events?

Yes; specify _____

No Unknown

At what age did your child do the following?

(Italicized areas reflect normal development)

_____ smiled (6 mths)

_____ sat alone (6 to 10 mths)

_____ talked in sentences (30 to 36 mths)

_____ walked by self (12 mths)

_____ held head up (3 to 4 mths)

_____ fed self (2yrs)

_____ crawled (6 to 10 mths)

_____ rode a bike (6 yrs)

_____ rolled over (6 mths)

_____ talked in single words (18 to 24 mths)

_____ pulled up (6 to 10 mths)

_____ established toilet training (2 ½ to 4 yrs)

How would you describe your child's approach to new situations?

Positive, jumps right in

Withdrawn, tends not to participate

Slow to warm up; cautious

How would you generally describe your child's overall mood?

Positive (happy, laughing, upbeat, hopeful)

Negative (depressed, cranky, angry, hostile)

Mixed but more positive, than negative

Mixed but more negative than positive

Which school is your child currently attending?

Is your child currently receiving special services in this school?

Yes; specify _____

No

Has your child ever failed a class or been held back for academic reasons?

Yes; specify grade: _____

No

Is your child expected to pass this school year?

Yes

No



New Client Questionnaire

Name : _____ Nickname: _____ Date: _____

Directions: While you will be meeting with your counselor shortly, it can be helpful to gather your thoughts and goals ahead of time. Please take a moment to respond to the following questions in your own words.

Your Reason for Coming Today: _____

Counseling Goals: (What you would like to be different after counseling? What are the main things you would like to work on changing in your life? If life was perfect, what would it look like?) _____
