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Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your protected health information. Your signature on this document acknowledges receipt of the HIPPA policies and Notice attached.

Many clients have indicated that they are able to get the most out of counseling when they are clear about their part and my part in the process. 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. Participation in therapy also has risks, including uncomfortable feelings and sensations. It may also require discussing unpleasant aspects of your life. The benefits generally outweigh the risks, however, and most participants in therapy see a significant reduction in feelings of distress, increased satisfaction in relationships, greater personal awareness, and insight, increased skills for managing stress and resolutions to specific problems. Working toward these benefits, however, requires effort and commitment on both our parts.

Payment Method
I currently accept Cash or Check. Debit or Credit Card are accepted with additional 3% fee.

Professional Fees (Clients with no insurance)
Normally, the first few sessions will be evaluative in nature. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. We will clearly define your goals and discuss treatment options and recommendations. I offer standard 45 to 50-minute sessions at a rate of $125.00 per session. My own experience in therapy and as a therapist also taught me the value of having longer sessions, so I also offer 80 to 90-minute sessions at a rate of $185.00. You may choose which length of session works best for you. Payment is expected at the time of the session unless prior arrangements have been made.

Appointments
Mutually, we will need to be considerate of each other's time and resources and keep our scheduled appointments. In the event you need to cancel, 24-hour notice is required to avoid

being charged for the full session. If appointments are cancelled in less than 24-hours a $30 cancellation fee will be charged.

Insurance
Please verify your insurance before services begin. Clients who carry insurance are responsible for their co-pay at the end of the session.

Professional Records
I am required by the Arizona Board of Behavioral Health Examiners to keep appropriate records of the psychological services that I provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in the session, and a general mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location in the office listed above. If records or information is requested to be sent to or shared with other health care providers, you will be asked to execute a Release of Information authorizing me to discuss your case or release records indicated on that Release.

Confidentiality
Maintaining your confidentiality is very important to me. What you say to me and the written records pertaining to our sessions are confidential and may not be revealed to anyone without your written permission. In the event you would like to have your information shared, I will have you sign a written authorization for release.

There are, however, several exceptions in which I am legally bound to take action even though that requires revealing some information about a client's treatment. Maintaining your safety and the safety of those in your life is very important to me and most exceptions to confidentiality involve matters of safety. If at all possible, I will make every effort to inform you when these will have to be put into effect. The legal exceptions to confidentiality (times when I am required to report or reveal client information) include, but are not limited, to the following:

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Department of Child Safety (DCS) or Adult Protective Services immediately. If you are a minor and tell me that you having sex with an adult, I will also be obligated to report this to both the police and DCS.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

4. If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either a. engaged in sexual contact with a patient, including yourself or b. is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this to their licensing board at the Arizona State Board of Behavioral Health Examiners (AZBBHE). I would inform you before taking this step.

Scope of Practice and Modalities of Treatment

I will work under my scope of abilities and cannot guarantee the outcomes that you might desire. I will work hard with you on developing a treatment plan that will help us towards your goals. I ask that you trust the process and be patient that change will not be instantaneous or evident at times. I am committed to providing you with the best possible counseling. I believe that counseling cannot only be very helpful, but can also be fun and interesting. In my quest to acquire sound clinical skills to assist you, I am trained in traditional psychotherapy modalities and also have additional training and certification in some specific treatment modalities. Not all clients and client issues are appropriate for all types of therapy and we will determine together which will be most helpful for you. You are always invited to give feedback about the particular modality we are using and inquire about other forms of treatment. I also welcome your independent investigation into these treatment modalities and will give you information and research cues so that you may acquire more information if you wish.

In addition to traditional "talk" therapy, I also utilize Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy and Cognitive Behavioral Therapy (CBT). For my younger clients, I provide Play Therapy, Theraplay ® and Sand Tray Therapy. I strive to maintain current certification and seek on-going training in these particular modalities, in addition to other required trainings to maintain my licensure.

I do not provide custody evaluations or recommendations or medication or prescription recommendations or legal advice, as these activities do not fall within the scope of my practice or expertise. Additionally, both parents of minors in treatment are entitled to information about the progress of their child. If there are unique custodial issues relevant to your minor, please advise me.

Contacting Me

It is important that you understand that therapy brings about awareness and change and that may initially cause some additional discomfort and distress. It is not uncommon for clients to continue to process distressing material between sessions. We will be monitoring your level of distress throughout this process and I encourage open disclosure of how this process "feels" to you. I will want to provide you with additional skills and support as needed.

During times of extra distress outside of sessions, you are welcome to call (480) 463-4793 or email maderawellnesscenter@gmail.com for additional support to make a sooner follow-up appointment. I will make myself available for these additional sessions if possible. I am often not immediately available by telephone but do check my phone messages periodically.

If I am out of telephone contact for any extended period of time, a message to that effect will be left on my voicemail. If, for any number of unseen reasons, you do not hear back from me or I

am unable to reach you, it remains your responsibility to take care of yourself until such time as we can talk. If you feel you are unable to keep yourself safe or you need to speak with a crisis person immediately, please go to your nearest emergency room or call the Central Arizona Crisis Line at (602)222-9444. Please do not leave emergent messages via text messaging as I have found this to be an unreliable form of communication.

Other Rights

We will work together to formulate a treatment plan after the first couple of sessions. If I assess that I cannot be of benefit to you, you will be given a number of referrals who might be more suited to your particular needs. If at any point during therapy I assess that I am not effective in helping you reach your therapeutic goals, I am obligated to discuss it with you and, if appropriate, terminate treatment. In such a case, you will be given a number of referrals to continue your healing. If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such communications will be taken seriously and with care and respect. Most often, discussing these matters helps the therapeutic process. You have the right to terminate therapy at any time. I consider it a privilege to walk the healing path with a fellow sojourner and am looking forward to walking with you!

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully (total 4 pages) and I have received the HIPAA Notice Form described above. I understand them and agree to comply with them:

Client name (print)	Signature	Date
Guardian/Parent name (print)	Signature	Date
Guardian/Parent name (print)	Signature	Date
Jose Luis Madera, LPC-15266 Therapist	Signature	Date

CLIENT INFORMATION

Please provide the following information and answer the questions below. The information you provide here is protected as confidential information.

Name: _____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Address: _____

_____

(Street and Number)(City) (State) (Zip)

Phone: _____ May we leave a voice or text message? □Yes □No

Additional Phone: _____ May we leave a voice or text message? □Yes □No

Work Phone: _____May we leave a voice or text message? □Yes □No

E-mail: _____ May we email you? □Yes □No

*Please note: Email correspondence and shared telephone accounts are not considered to be a confidential medium of communication.

I authorize Madera Wellness Center, LLC to contact me using the information listed above.

_____

Client name (print) Signature Date

_____

Guardian/Parent name (print) Signature Date

_____

Guardian/Parent name (print) Signature Date

HEALTH INSURANCE INFORMATION

Please provide the following information and answer the questions below. The information you provide here is protected as confidential information. If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company.

Insured's information (the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable). Please write the information how it appears on your card.

Name of Insurance or Program Name: _____

Insured's insurance ID number: _____

Policy group number: _____

Insured's place of employment (Name, Address and Phone Number): _____

_____

Patients' relationship to insured: □ self □ spouse □ child □ other_____

If the below requested information was listed in the Client Information form, please check here □

Name of insured: _____

Street city state & zip code address of insured: _____

Insured's date of birth: _____

Telephone: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Madera Wellness Center, LLC, and authorize Madera Wellness Center, LLC to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment. I ensure that the information that I have written is true and to the best of my abilities. If at any point I have a change to the above-mentioned information, I will notify Madera Wellness Center, LLC to make any changes.

_____ Date _____

Signature of Insured

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1(low)-10 (high), how would you rate your relationship? _____

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

_____

_____

_____

Family Structure:

Who were/are your caregivers?_____

Siblings (list gender and age):_____

_____

_____

_____

Have you experienced any traumatic events in your life? □ No □ Yes (describe the event)_____

_____

_____

_____

_____

How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

Are you currently experiencing sadness, grief or depression? (Please circle)

□ No □ Yes

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? (Please circle)

□ No □ Yes

If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe? _____

Do you drink alcohol more than once a week? □ No □ Yes, Frequency: _____

How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

What significant life changes or stressful events have you experienced recently?
_____
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY: *In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).*

Please Circle List Family Member

Alcohol_____

Substance Abuse_____

Anxiety_____

Depression_____

Domestic Violence_____

Eating Disorders_____

Obesity_____

Obsessive Compulsive Behavior _____

Schizophrenia _____

Suicide Attempts _____

Other: _____
_____

Are you employed? □No □Yes, Where? _____
Do you enjoy your work? Is there anything stressful about your current employment?
_____
_____
Are you in school? □No □Yes, Where? _____
□ Full-time student □ Part-time student

Do you enjoy your school? Is there anything stressful about your current school?

_____

_____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication (non-psychiatric)?

□ No □ Yes

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ No □ Yes

Please list: _____

_____

Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

Who is part of your support system?

_____

_____

_____

_____

_____

What do you consider to be some of your strengths?

_____

_____

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

_____

_____

_____

What would you like to accomplish out of your time in therapy(goals)?

_____

_____

_____

_____

_____

_____