



Welcome to my counseling practice. Since you are receiving this introduction letter, you have likely scheduled your first appointment with me. The first session is usually focused on the clinical assessment process and is unlike “counseling” in that it is very structured with the counselor asking a multitude of questions in an attempt to get an overview of the issues that have brought you to counseling. After your first session, I will be able to give you some initial feedback and a tentative plan on how we can move toward your goals for our time together.

Since many people I see have never been in counseling before, I find it useful to put some of my policies in this introductory letter for your information. Even if you have been in counseling before it would be useful to review these policies because some of them might have changed or be unique to my practice.

Appointments. Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve an hour or more for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. Appointments for Monday must be canceled by the prior Friday at 5:00 P.M. ***You will be billed for appointments you fail to cancel in accordance with this policy. In addition, if you arrive late to an appointment, the end time will remain as scheduled and you will be charged for the full appointment hour I have reserved for you.***

Length of Sessions. There are sometimes misunderstandings about the length of sessions. Therapy sessions, as defined by the American Medical Association Current Procedural Terminology coding, are 45-50 minutes, not one hour. This is known as a “therapeutic hour.” Longer appointments are sometimes useful and can be scheduled if you let me know you would like to do this ahead of time. Please note that some insurance companies will not pay for an appointment outside of the traditional 45-50 minutes.

Confidentiality. Subject to the provisions outlined in the Informed Consent and HIPAA Privacy documents in this New Client Packet, I will do the utmost to maintain your confidentiality. This includes the fact that you *are* a client. If we encounter each other in the community, I may nod or smile, but I will not acknowledge you as anyone I know. I’m not trying to be rude, but attempting to maintain your confidentiality.

Phone Contact. I have a strong preference for face-to-face contact when I do counseling. I believe that personal contact facilitates a greater depth of understanding and makes our time together more productive. However, there may be times when some limited telephone counseling is warranted. In those situations, you need to be aware that insurance companies and managed care organizations generally do not reimburse for these services. Telephone counseling should be scheduled for a mutually-agreeable time and will be billed at \$40 for each 15 minute period of counseling during normal business hours. Evenings, nights and weekends are billed at an additional premium.

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***Lighting the way towards hope and recovery***

# Informed Consent for Assessment and Treatment

## Michael Finecey

Therapy offers a unique relationship between the client and therapist. This document has been developed in order to ensure that there are no misunderstandings about the various aspects of counseling services provided at NPCC. Although this document is long and perhaps complex, it is important that you read it carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between you and North Pointe Counseling Center, with whom I am contracted to provide counseling services. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it.

### Education and Services

My credentials include a Master of Arts degree in Professional Counseling and a Certificate of Advanced Graduate Studies (CAGS) in Trauma, Abuse and Deprivation I am dual licensed by the Arizona Board of Behavioral Health Examiners as a Licensed Professional Counselor (LPC) and a Licensed Individual Substance Abuse Counselor (LISAC.)

I offer counseling and consultation services to adults for individual, couple, and family therapy. I specialize in the treatment of trauma, abuse, and deprivation, including such issues as traumatic life events, abusive relationships, painful life history, addictive behaviors, self-harm, and loss. Clients who present in counseling with violent behaviors or certain personality disorders as their primary problem will be referred to other professionals or programs that specialize in these areas.

### Confidentiality Statement

Your emotional, physical, and spiritual wellbeing are of utmost importance to me. I am committed to your care and to the confidentiality of all personal information shared in our therapy sessions, except in circumstances governed by law. State and federal laws define the limitations of confidentiality as when there is a real or potential danger to you or others, when the courts issues a subpoena, or when child/elder abuse or neglect is involved.

There are other possible circumstances when information may be released, including disclosure required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against me, to comply with the United States Patriot Act, and to comply with other federal, state, or local laws. In addition, your case may be discussed with other professionals for consulting purposes. On those occasions, your name will be withheld from our discussions. The rules and laws regarding confidentiality, privacy, and records are complex. The HIPAA NOTICE OF PRIVACY PRACTICES included with this document details the considerations regarding confidentiality, privacy and your records. Periodically, the HIPAA NOTICE OF PRIVACY PRACTICES may be revised. Any changes to these privacy practices will be provided. **It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.**

_____ Initials	<b>I have read the HIPAA NOTICE OF PRIVACY PRACTICES and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the HIPAA NOTICE OF PRIVACY PRACTICES may be revised.</b>
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If you would like me to speak with another healthcare provider or obtain records from previous treatment, you will need to sign a "Release of Information" form. If one of the unusual circumstances previously stated does arise when I am forced to release information about you, I will personally contact you and will do everything in my power to release minimal information.

It is important to be aware that I use a number of electronic tools in my practice, including computers and the internet, email, PDA, fax machines, telephone, and cell phone. I may use these tools to store or communicate information about you and your treatment. While reasonable backup, security, and other safeguards are in place, there is always some risk of inadvertent disclosure of information that comes with using these tools. By signing this informed consent, you agree to accept the risk of disclosure that comes with tools that I use in my practice.

During times when I am out of town or otherwise unavailable, I will typically have another licensed therapist on call for me. I reserve the right to disclose confidential information from your records and our time together, including personally identifiable information, to this on-call therapist to facilitate the coverage of your care in my absence.

In the event of my death, retirement, or incapacity, the records for my clients who are actively receiving services (seen within the last month) will be given to Michael K. Finecey, LPC, North Pointe Counseling Center, to facilitate the continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by a North Pointe Counseling Center designated records custodian. The custodian will be responsible for satisfying records requests and destroying records when the legal time frames for records retention are satisfied.

#### **Financial Agreement**

Payment is expected at the time the service is rendered unless other arrangements have been made. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. Currently, the fee for an initial assessment is \$135.00; the fee for a 45-50 minute individual counseling session is \$120.00; and the fee for a 60-75 minute family or couples' session is \$135.00; a 90-minute session is \$180.00. I also offer 15-minute phone sessions for \$40.00 should you feel that this would be beneficial for your needs between regular in-office sessions. I accept cash, check, or Visa/MasterCard/Discover/American Express. ***Effective 1/1/12, there will be a \$5.00 credit card surcharge per session charged.*** All payments are made to North Pointe Counseling Center. I do not participate in managed care insurance plans, but will provide you with a superbill that you can submit to your insurance company for reimbursement. ***You are responsible for the full fee regardless of your insurance company's reimbursement policy.***

I reserve the right to change my fees with 30 days' notice, and to use the services of a third-party collections service, when necessary. Refunds are not made after the services have been rendered.

#### **No-Show and Cancellation Policy**

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. Appointments canceled at the last minute are very detrimental to my practice, therefore, a 24 hours' notice is required for cancellations or you will be charged a cancellation fee. A no show/no call will be charged full fee. A cancellation within 24 hours will be charged \$95.00. A cancellation greater than 24 hours will be charged \$0.00. Repeated late cancellations or missed appointments may result in termination of therapy. ***In addition, if you arrive late to an appointment, the end time will remain as scheduled and you will be charged for the full appointment hour I have reserved for you.***

### **Emergencies**

My practice does not have the capability to respond immediately to counseling emergencies. In the event of a life-threatening emergency, please call 911 or go to your local Emergency Room. You may also utilize community crisis hotlines (Empact 480-784-1500; Banner Help Line 602-254-4357). Established clients with an urgent need to make contact with me may call the cell phone number provided at your first session, but an immediate response is not guaranteed.

### **Purpose and Limitations of Therapy**

Counseling has been shown to have many benefits, including better relationships, solutions to specific issues, and significant reduction in feelings of distress. However, there are no guarantees of what you will experience. The process of therapy involves working through tough personal issues that may result in uncomfortable emotions such as anger, fear, or frustration. Attempting to resolve these issues may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use, education, relationships, or any other area of your life. Sometimes, a decision that is personal growth for one family member is viewed negatively by another family member. Change can be easy, but usually it is slow and frustrating. In family counseling, interpersonal conflict may increase as we discuss family problems and issues.

In most cases, one or more mental health diagnoses will be rendered during the process of assessment and treatment. Some diagnoses may affect employment in high security or safety sensitive positions or affect your ability to obtain future insurance.

You have the right to refuse any recommended treatment or to withdraw consent to therapy and to be advised of the possible consequences of withdrawal or refusal. I welcome your input and questions about our course of treatment. *Your satisfaction in therapy is very important to me!*

Our relationship is very unique and it is exclusively a therapeutic, professional relationship. Thus, it is inappropriate for a client and therapist to have a social relationship. Bestowing gifts and attending family or religious functions would be a violation of the boundaries of our therapeutic relationship that serves to protect your confidentiality.

If you ever feel you have been treated unfairly or disrespectfully, please talk with me about it. This is never my intention, but at times misunderstandings can result in hurt feelings. Addressing these issues right away is important so that your progress in therapy is not hindered.

### **Litigation Considerations**

If you become involved in the legal system (divorce, custody, civil litigation, criminal activity, etc.) you can expect that I will not make recommendations, testify, or get otherwise involved in your legal activities. It is an inherent conflict of interest for a treating professional to also offer evaluations or opinions in legal matters. If a client has these expectations, it can affect their willingness to disclose personal information vital to treatment. If you need an evaluation for legal reasons, I will make a referral to an outside, unbiased professional who can perform this service. ***In signing this agreement, you agree that you will not call me as a witness to testify or to expect recommendations or other involvement in your legal activities.***

**STATEMENT OF UNDERSTANDING**

I have read and understand this information and am giving my informed consent to treatment. In the case of a minor child, I affirm that I am the custodial parent or legal guardian of the child, and I authorize services for the child under this agreement.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Leave Voicemail Acceptable:  Yes  No

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

In the case of minor children, please specify the following:

Full Name of Minor: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Full Name of Minor: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

For office use only - verification that client has read and understands informed consent document

Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

# HIPPA Notification

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Privacy is a very important concern for all those who come to my office. This Notice of Privacy Practices describes how I protect your personal health information (PHI), tells how I may use and disclose your clinical information, and explains certain rights you have regarding this information. I am providing you with this notice in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and will comply with the terms as stated. I will obey the rules of this notice as long as it is in effect, but if I change it I will keep copies in my waiting room. You can get a copy from me at any time.

## **How I Use and Disclose Your Personal Health Information**

I protect your personal health information from inappropriate use and disclosure. Your information is obtained in the course of providing services to you and is related to your medical records, psychotherapy visits, and payment information. It is likely to include your history, reasons you came for psychotherapy, diagnoses, progress notes I make (but not psychotherapy notes I may choose to make), records I get from others who worked or work with you or evaluate you, and billing and insurance information. I will not disclose any personal health information without your written authorization, unless such disclosure is permitted or required by law. The law permits me to disclose your health information without a signed authorization from you when I am using it to provide you with your mental health care. For example, I use your clinical information to plan your care, to decide how well your psychotherapy is working, when I talk with other professionals who are also treating you, for teaching and training other psychotherapy professionals, and for mental health research.

## **How Your Protected Health Information can be Used and Shared**

When your information is read by me, in the law that is called "use." If the information is shared with or sent to others outside this office, in the law that is called "disclosure." Except in some special circumstances, when I use your PHI here or disclose it to others, I share only the minimum necessary for those other people to do their jobs. The law gives you rights to know about your PHI, how it is used and to have say in how it is disclosed (shared), and so I will tell you more about what I do with your information.

## **Uses and Disclosures of PHI in Health Care with Your Consent**

After you have read this Notice you will be asked to sign a separate consent form to allow me to use and share your personal health information. In almost all cases, I intend to use your personal health information here, or to share your personal health information with other people or organizations to provide treatment to you, to arrange for payment for our services, or some other business functions called health care operations. Generally, I may use or disclose your PHI for three purposes: treatment, obtaining payment, and what are called health care operations.

## **Treatment and Care Management**

I need information about you to provide care to you. You agree to let me collect the information and to use it and share it to care for you properly. Therefore you must sign the Consent form before I begin to treat you, because if you do not agree and consent I cannot treat you. Health information about you may be used or disclosed to assist treatment by health care providers. This would include treatment provided to you by me, and coordinating your care with other providers such as physicians, hospitals, or nursing homes. For example, I may refer you to other health-care or medical professionals or consultants for services I cannot provide. When I do this I need to tell them some things about you and

your conditions. I will get back their findings and opinions, and those will go into your records here. If you receive treatment in the future from other professionals, I can also share your health information with them.

### **Payment**

I may use your information to bill you, your insurance, or others so I can be paid for the treatments I provide to you. I may contact your insurance company to check on exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and the changes I expect in your conditions. I will need to tell them about when we met, your progress, and other similar things.

### **Health Care Operations**

Health information may be used and disclosed to carry out health care operations, which includes using your health information to see where I can make improvements in the care and services I provide. I may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If I do, your name and personal information will be removed from what I send. Information may be disclosed to a law enforcement agency to respond to a subpoena, to help identify or locate a suspect or missing person, or to provide information about a victim of a crime. Information may also be shared for certain types of public health efforts involving communicable diseases. In addition, information may be disclosed to the appropriate governmental authorities to avoid a serious threat to your health and safety or that of another person or the public, or when there is reason to suspect neglect, abuse or domestic violence. Information will also be shared about a deceased person when necessary with coroners, medical examiners, funeral directors, or with organizations involved with organ, eye or tissue donations, to individuals involved in your care. Your health information may be disclosed to a family member, other relative or close personal friend assisting you in receiving or obtaining payment for health care services. I will disclose your health information to these individuals only if you tell me to do this or if I can reasonably infer that you do not object. I may also disclose your health information to disaster relief organizations to assist family members or friends in locating you or learning about your general condition in the event of a disaster.

### **Appointments, Information or Services.**

I may contact you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you. I may also use or disclose your health information for judicial or administrative proceedings, for specialized government functions, for workers' compensation or similar purposes. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I can usually arrange that. Just tell me.

### **Business Associates.**

There are some tasks I may hire other businesses to do for me. Examples include a copy service used to make copies of your health records, and a bookkeeper. These business associates need to receive some of your health information to do their jobs properly. To protect your privacy, they agree in their contract with me to safeguard your information.

### **Obtaining Your Authorization for Other Uses and Disclosures**

I will not use or disclose your health information for any purpose not specified in this Notice of Privacy Practices unless I obtain your express written authorization to do so. If you give us your authorization, you may revoke it at any time in writing, in which case we will no longer use or disclose your health

information for the purpose you authorized, except to the extent we have relied on your authorization in providing benefits. I may refuse to enroll or continue to provide benefits to you if you decide not to sign an authorization form.

**Your Rights Regarding Your Health Information Right to Inspect and Copy.**

You have the right to inspect or request a copy of personal health information about you that I maintain and that I may use in making decisions about your care. Your request should describe the information you want to review. In limited circumstances, you may not be able to review or copy certain information. These include psychotherapy notes, or information collected in anticipation of a claim or legal proceeding. If I determine that reviewing your records may cause substantial and identifiable harm to you or others or would have a detrimental effect on your treatment, on our professional relationship, or on your relationship with parents, guardians, spouses, or children, I may deny access to your records. A patient over the age of twelve may be notified of any request by a qualified person to review his or her record, and if the patient objects to the disclosure, I may deny the request for access. I may charge you a reasonable fee for copying.

**Right to Request Amendments.**

You have the right to request changes to any health information I maintain about you if you state a reason why this information is incorrect or incomplete. I may not agree to make the changes you request. If I do not believe the changes you requested are appropriate, I will notify you in writing how you can have your objection to my decision included in my records.

**Right to an Accounting of Disclosures.**

You have the right to receive a list of disclosures of your health information that have been made by me. The list will not include disclosures made for certain types of purposes, such as disclosures for treatment, payment or health care operations or disclosures you authorized in writing. Your request should specify the time period for which you want this list, which can be no longer than six years and may not include dates prior to April 14, 2003. The first time you ask for a list of disclosures in any 12-month period, I will provide it for free. If you request additional lists during a 12-month period, I may charge you a fee to cover our costs in providing the additional lists.

**Right to Request Restrictions.**

You have the right to request restrictions on the ways in which I use and disclose your health information for treatment, payment and health care operations, or disclose this information to disaster relief organizations or individuals who are involved in your care. I may not agree to the restrictions you request.

**Right to Request Confidential Communications.**

You have the right to ask me to send health information to you in a different way or at a different location if you believe that you may be endangered by my ordinary form of communication. You must state in your request that you believe you will be endangered by my ordinary form of communication but you do not have to explain why you believe this is the case. You may ask me to send health information to you in a different way or at a different location. Your request should also specify where and/or how I should contact you. We will accommodate all reasonable requests.

**Right to Paper Copy of Notice.**

You have the right to receive a paper copy of this Notice of Privacy Practices at any time. You may receive a paper copy even if you have previously requested to receive this Notice electronically.

**Uses and Disclosures Where You have an Opportunity to Object**

If I want to use your information for any purpose besides those described above, I need your permission on an **authorization form**. If you do authorize me to use or disclose your health information, you can cancel that permission, in writing, at any time. After that time I will not use or disclose your information for the purposes that we agreed to. Of course, I cannot take back any information that I had already disclosed with your permission or that I had used in my office. Occasionally, with your permission and if we determine this to be helpful to your care, I can share some information about you with your family or close others. I will only share information with those involved in your care and anyone else you choose such as close friends or clergy. I will ask you about whom you want me to tell what information about your condition or treatment. You can tell me what you want, and I will honor your wishes, as long as it is not against the law. If it is an emergency, so that we cannot ask if you disagree, I can share information if I believe that this is what you would want and if I believe it will help you if I do share it. If I do share information in an emergency, I will tell you as soon as I can. If you don't approve I will stop, as long as it is not against the law.

**If You Have Questions or Problems**

If you need more information or have questions about the privacy practices described above, please speak to me. If you have a problem with the way your health information has been handled, or if you believe your privacy rights have been violated, contact me. You have the right to file a complaint with me and with the Secretary of the Department of Health and Human Services. I promise that I will not in any way limit your care here or take any actions against you if you complain.

**Effective Date**

This Notice of Privacy Practices is effective as of April 14, 2003.

## Client Information

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Check if okay to leave a message at: Home \_\_\_\_ Work \_\_\_\_ Cell \_\_\_\_ Email \_\_\_\_ Other \_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Level of education: HS \_\_\_\_ College \_\_\_\_ Graduate Degree \_\_\_\_ Other: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Years married: Present marriage \_\_\_\_ Previous marriage(s) \_\_\_\_

Name of Spouse: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

<u>Children's Names</u>	<u>Sex</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

If client is a minor, client resides with: Mother \_\_\_\_ Father \_\_\_\_ Both \_\_\_\_ Other \_\_\_\_

Referred by (optional): \_\_\_\_\_ May we thank them for referral? Yes \_\_\_\_ No \_\_\_\_

If referred by a doctor, may we have permission to contact that doctor? Yes \_\_\_\_ No \_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

What hobbies, if any, do you have? \_\_\_\_\_

What do you do for recreation, physical activity?  
 \_\_\_\_\_

Do you smoke? Yes \_\_\_\_ No \_\_\_\_ If yes, how much/day? \_\_\_\_\_

How would you rate your current physical health? Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_

Are you currently experiencing any physical problems? Yes \_\_\_\_ No \_\_\_\_ If yes, please explain: \_\_\_\_\_

Date of last physical examination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous hospitalizations:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_

Have you ever been an inpatient for mental health reasons? Yes \_\_\_\_ No \_\_\_\_ Approx. dates: \_\_\_\_\_

Are you currently suicidal? Yes \_\_\_\_ No \_\_\_\_ Suicidal thoughts only? Yes \_\_\_\_ No \_\_\_\_ Previous suicide attempts? Yes \_\_\_\_ No \_\_\_\_

Any aggressive/violent thoughts or acts? Yes \_\_\_\_ No \_\_\_\_ Any past aggressive/violent thoughts or acts? Yes \_\_\_\_ No \_\_\_\_

Family Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If you are taking any medications, please list:

Medication(s) – Prescription and Over the Counter	Dosage	Prescribed For

