Gary Breuer, LPC, PLLC / Client Paperwork

Client Information

(Please complete and sign all forms, and bring all pages to your first session.)

Name: _____
Last First Middle Initial

Date of Birth: _____ / _____ / _____
Month Day Year

Street: _____ **Unit:** _____

City: _____ **State:** _____ **Zip:** _____

	Confidential Voicemail?		Can Message Be Left With Another Person?	
Home Phone: _____	Y	N	Y	N
Cell Phone: _____	Y	N	Y	N
Work Phone: _____	Y	N	Y	N

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Alt. Emergency Contact Name: _____

Alt. Emergency Contact Phone: _____

How did you hear of this counseling practice? (Check One)

___ PsychologyToday.com
___ Other online search
___ Family member or friend
___ Physician or other Healthcare Professional
___ Other _____

Client Rights

Any person who receives services for mental health, alcoholism, drug abuse or developmental disability is guaranteed certain rights. Among these rights are the following:

1. You must be treated with dignity and respect, free of any form of abuse.
2. You have the right to have your therapist make fair and reasonable decisions about your treatment.
3. You cannot be treated unfairly because of your race, national origin, sex, religion, age, disability or sexual orientation.
4. You must be provided prompt and adequate treatment and other services which are appropriate to your individual needs.
5. You must be allowed to participate in the planning of your treatment.
6. You have the right to discuss positive and negative effects of your treatment and to discuss alternative treatments with your therapist.
7. No treatment may be given without your consent except in an emergency.
8. You have the right to know the cost of your treatment and to discuss these costs with your therapist.
9. You will not be filmed or taped without your written permission.
10. Information regarding your treatment must be kept confidential unless you have released them.
11. Your records cannot be released without your signed authorization, except in other instances as outlined by HIPAA. (See HIPAA Notice of Privacy Practices.)
12. You have the right to see your records and to discuss them with your therapist.
13. You may challenge the accuracy of your records and have corrections placed into the record.
14. If you feel your rights have been violated, you may file a grievance. The grievance policy is outlined under the policies section.

I have read and understand these rights.

_____ _____

Client (or Parent/Guardian) Signature Date

Receipt of Notice of Privacy Practices

I have read, understand, and have been provided a copy (via website or hard copy) of Gary Breuer, LPC, PLLC's privacy policies regarding the protection of my health information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Client Signature Date

Authorization for Contact by Telephone/Verbally in Event of Breach of PHI

I authorize Gary Breuer, LPC, PLLC to provide notice to me by telephone or verbally in the event of a breach of my Protected Health Information (PHI) by Gary Breuer, LPC, PLLC.

Such conversation shall be documented by Gary Breuer, LPC, PLLC.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me, pursuant to this authorization, shall not be simply for the administrative convenience of Gary Breuer, LPC, PLLC.

_____ _____

Client (or Parent/Guardian) Signature Date

Informed Consent To Treatment

PLEASE READ CAREFULLY

Psychotherapy is a process designed to help people learn to function better and feel better in their daily lives. People seek therapy to change emotional, interpersonal or behavioral issues. In many instances people who do not receive treatment for emotional problems report that their distress increases and this can lead to a significant disruption in mental, interpersonal and physical functioning. Initially, many people report feeling an increase in distress as they come to grips with important issues. Through therapy, people oftentimes make changes in personal coping strategies, careers or relationships. These changes can be distressing to the individual, to family members and to friends. It is important that you understand the risks and implications of beginning therapy, discontinuing therapy or changing your treatment plan. Your specific situation is unique and will be discussed in detail with your therapist.

I realize that my initial treatment plan should be developed with my therapist and approved by me. My treatment plan will evolve as my needs change and each change should also be discussed and approved by me. I understand that my therapist and I will review my treatment plan at least annually. I understand that my therapist and I should regularly discuss the implications of my continuing in therapy, adjusting the modality of therapy, seeking alternative treatment, and the implications of terminating therapy. I also understand that it is my right to make any of these decisions. I further understand that my therapist is responsible to provide therapy which he believes to be effective and appropriate to my needs. I am also aware that my therapist consults regularly with a consultation team of therapists and therefore may discuss my case if guidance is needed (client name and other identifying information will not be shared). I understand that any communication via cell phone or email may be heard or read by a third party, as these are not secure forms of communication. Therefore, I understand that my therapist does not communicate clinical information over email, text, or other electronic means and prefers to discuss clinical information or concerns only in-person or over the phone.

For parents/guardians of children:
I attest that I have the legal right to consent to treatment for this child.

I hereby consent to begin therapy.

_____
Client Name (Print)

_____ _____
Client (or Parent/Guardian) Signature Date

Policies of Gary Breuer, LPC, PLLC

PLEASE READ CAREFULLY

Billing and Payment

My billable rates are as follows:

- Diagnostic intake assessment (60-minutes)……..$200
- 60-minute psychotherapy (individual or family)……..$180
- Report writing, consultations, client telephone contact……$180/hour (prorated)
- Late Cancellation/Missed Appointment……..Full Scheduled Session Fee
- Campbell Interest & Skill Survey……..$50
- Myers-Briggs Type Indicator……..$50

Additional session-length times are available upon request and based on clinical need and are prorated at the above hourly rate.

Copies of records, if requested, are charged at $.75 per page plus administrative costs such as time (prorated to regular hourly fee of $180) as well as postage costs.

I am not in-network with any insurance networks. However, as a licensed clinician, my services are reimbursable by insurance companies. If you are seeking reimbursement from your insurance company, I will provide you with a Superbill (a summary statement of charges and payments received), which you may submit to your insurance company for reimbursement directly to you. A Superbill contains all the necessary information needed by the insurance company to process your claim. Note: A provider cannot guarantee reimbursement by your insurance company, therefore, it is best for you to contact your insurance company and inquire about the benefits of your specific plan prior to beginning services.

Clients are responsible for payment of services at the time of service. Clients are responsible for the full payment of the session fee at the time of service. It is a requirement that a current credit card (VISA, MasterCard, Discover, or American Express) is on file, however, other forms of payment such as cash or personal check are accepted. I also accept HSA's as a form of payment. Credit card information is kept on file for clients who wish to pay for ongoing sessions via credit card or in the event that a client presents without another form of payment. The services listed above are non-refundable.

If you overpay on your account, you will be promptly reimbursed in the amount that you overpaid. If you have more than one unpaid session, I reserve the right to suspend services until your account is paid in full. If outstanding money is owed, you will receive a bill at the end of the month. If your account is not in good financial standing, you may be referred to

another provider. If you default on your payments after a 60-day time period and without payment arrangements, collection or court-related action may be taken against you. In such a case, you would be liable for collection or court-related costs. For any unpaid client balance, a monthly interest rate of 3.0% will be charged to your account. An account is considered past due if full payment has not been received after 30 days of the receipt of your bill. Additionally, postage and handling will be charged for all overdue accounts. In accordance with HIPAA, I have the right to release any pertinent treatment information, via paper or electronic means, to obtain payment for services.

I am happy to answer any questions you have about billing and payment. It is best to discuss any concerns/questions immediately so that financial matters do not interfere with your therapy.

Scheduling/Contacting Your Therapist/Emergency Services

I am typically able to respond to messages within 24 business hours. **My office number is unable to receive or send text messages and I do not use email for communications such as scheduling**, so please call my office number to schedule appointments or request changes to existing appointments. Please be mindful that if you are unable to answer return phone calls and your voicemail box is full, I will be unable to leave you a message. I do not send out appointment reminders, so it is your responsibility to accurately document your scheduled appointments at the time they are made. Please note that my office number is not an emergency number. In the case of a mental health emergency, please report to the nearest hospital emergency room or urgent care clinic, dial 911, or contact the Maricopa County Crisis Hotline at 1-800-631-1314 or 602-222-9444.

Missed Appointments/Late Cancellations

If missed appointments or late cancellations (when less than a 48-hour notice is given) occur, the full session fee will be charged. Because of the nature of private practice, and the amount of time we schedule for an appointment, that time is viewed as a contract between you and I. When late cancellations or missed appointments occur, that time cannot be given to another client in need of services. If you cancel and/or miss two consecutive scheduled appointments and/or if you haven't been seen for 30 days without a future appointment scheduled, you may be considered an inactive client and may be discharged. If you are seeking reimbursement from your insurance company, please know that insurance companies do not reimburse for missed appointment charges.

Confidentiality

All of our sessions are strictly confidential. My professional code of ethics prevents me from discussing what is said during sessions with anyone other than therapy participants, or from releasing any records without the written permission of my client(s). The only exceptions to this are if someone is in danger of being harmed (i.e. abuse of a child, elder or other vulnerable adult), or if the law explicitly states that confidentiality provisions do not

apply in a particular case. I may, in certain cases, consult with a colleague if I feel that I may need guidance or another opinion; in such cases, the names or identifying information of clients will not be shared. If therapy involves the participation of a partner or spouse, I do not guarantee confidentiality among therapy participants. In these cases, I will, however, use my professional discretion in deciding whether to disclose communications relayed to me. I do not connect with clients via social media (i.e. LinkedIn, Facebook, etc.) in order to protect client confidentiality. If I see clients in public, I do not initiate contact or conversation with them in order to maintain confidentiality; in those situations, it is up to clients if they wish to acknowledge or greet me, but regardless, neither the nature or details of the therapeutic relationship will be discussed by me.

Court-Related Professional Limitations

It is agreed by clients, or the parents of child or adolescent clients, that they will not request that the therapist become involved at any time or in any way in any divorce, custody, or other legal litigation or proceeding. Clients express understanding that the assessment of, or expert testimony for, cases such as child custody, divorce, or any other legal or forensic issue is a distinct area of professional specialty, and are not within the training or expertise of Gary Breuer, LPC, PLLC. If you are seeking any form of legal testimony or evaluation, I am able to provide an appropriate referral or recommendation to a specialist in this area.

Children and Adolescents

Any person under the age of 18 who is not emancipated needs parental consent for treatment. Treatment with children and adolescents may include family or individual therapy, or a combination of the two, depending on clinical needs.

Safe Harbor

If individual therapy with the child or adolescent is deemed most appropriate, parents acknowledge and agree that the therapist's office is a **safe harbor** – a place where the child or adolescent can be truthfully assured that the details discussed in therapy will not be disclosed to third parties (including parents) without the explicit consent of the child or adolescent. In these cases, I usually request that parents be involved in the assessment stage of therapy to obtain their input as to the nature of the problem, and it may occasionally be beneficial for family members to join-in on some therapy sessions (with the permission of the child or adolescent). However, during therapy, as sensitive issues are often discussed, it is therefore agreed that information shared during sessions will be kept confidential between the child or adolescent and therapist. This allows the child or adolescent to develop trust in the therapist and feel safe discussing any matters, concerns, or issues in their life, with the assurance that what is discussed in therapy will not be used to interfere with or create problems in the child or adolescent's relationships with either parent or other family members. It is understood that the child or adolescents' therapy is

solely for his or her benefit. If other family members are in need of services, appropriate referrals can be provided.

Therefore, in cases of child or adolescent therapy, neither parent shall permit his or her attorney to request nor subpoena the notes from the therapist regarding the child or adolescent's treatment to a trial, hearing, deposition, or arbitration. It is understood that neither parent shall, nor will either parent permit his or her attorney to, demand answers from either the therapist or the child to questions about the content of the therapy, nor will they request that the therapist share any opinions reached as a result of the therapy with either parent, with either attorney, or with any other third party, without the child or adolescent's explicit consent. Any party, or his or her attorney, who seeks to interrogate or subpoena the therapist shall be liable for all attorney fees and costs incurred to resist answering discovery requests or to quash a subpoena. It is understood, however, that the therapist is obligated to provide required disclosures in cases such as the suspected abuse of a child, elder or other vulnerable adult, or to respond to a court order issued by a judge. The conditions outlined in this section shall remain in effect both during the therapy timeline and after therapy has ended.

Referral Services

I am not a physician and therefore do not prescribe medication. If a medical evaluation is warranted, I am happy to provide you with an appropriate referral. If you require more intensive care, such as day treatment or inpatient care, a referral can be made to a facility that can accommodate your needs. If I believe that you would be better served by a different provider or type of therapy, I will discuss this with you and provide you with an appropriate referral.

Process and Termination of Therapy

As each person is unique, each person tends to approach therapy with different goals and needs in mind. Some people seek therapy to address a specific issue or concern, and may later return to therapy regarding a different concern or issues related to a different stage of life. Others decide to continue therapy beyond the resolution of their presenting concerns to continue to work on furthering their personal growth and development. Since each person is unique, each person will therefore have a uniquely different experience of therapy. How each person engages in the therapeutic process and the therapeutic relationship can often mirror how he/she processes and evaluates other situations and relationships in his/her life. The process of therapy, the therapeutic relationship, and the termination of therapy are vital aspects of therapy. The treatment goals, the pacing of sessions, and the eventual termination of therapy should be discussed between the client and therapist in advance in an effort to enable the client to make the most informed decisions regarding his/her care. Occasionally, in therapy, strong or difficult emotions may arise that may feel overwhelming for a client. Every attempt is made by the therapist to time and pace the therapy to mitigate and effectively manage such experiences. If you are

in need of a different provider or level of care to meet your needs (see *Referral Services* section above), an appropriate referral will be made and services with myself may be terminated or suspended.

Records

Records are maintained according to state law and HIPAA. You are entitled to a copy of your records by submitting a request in writing. Please contact me with any questions pertaining to records. Because these are professional records, they can be confusing or misinterpreted; therefore, it is recommended to first request a records review with me, or have the records sent to another professional who can help you interpret them. In the event of practice closing or death of practitioner, records will be forwarded to and maintained by another licensed mental health practitioner for their duration per state law.

Grievance Policy

If you are unhappy with the services you are receiving, it is requested to talk with me so that I may respond to your concerns directly. Such concerns will be taken seriously and met with care and respect. If you believe that appropriate resolution has not been attained, you may file a formal grievance with me in writing within 45 days of the time you become aware of the problem. I will investigate your grievance and attempt to resolve it. Unless the grievance is resolved informally, I will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report. If you and I agree with the report and recommendations, the recommendations shall be put into effect within an agreed upon time frame. If you are not happy with my report and recommendations, you may request mediation with a neutral party agreed upon by you and I. The cost of such mediation will be split equally between you and I, unless otherwise agreed upon. If mediation is unsuccessful, arbitration can be settled in Maricopa County in accordance with the rules of the American Arbitration Association. You may, instead of filing a grievance, at the end of the grievance process, or any time during it, contact the Arizona Board of Behavioral Health Examiners at www.azbbhe.us, or take the matter to court if you believe your rights have been violated. No adverse action will be taken against you if you file a grievance.

I agree to the aforementioned policies (totaling 5 pages).

_____ _____
Client (or Parent/Guardian) Signature Date

_____ _____
Client (or Parent/Guardian) Signature Date

Credit Card Authorization

Please Note: *Clients may use cash or check as forms of payment. However, it is required that all clients have a credit card on file. Credit card information is on file for clients who wish to pay for ongoing sessions via credit card or for clients who do not present with another form of payment. Credit card information is safeguarded and is not accessible to any third parties.*

I authorize Gary Breuer, LPC, PLLC to keep my credit card on file and/or to charge my credit card for any balance due.

Credit Card Information

Client/Patient Name: _____

Cardholder Name: _____
(As it appears on card.)

Credit Card Type: ___ VISA ___ MasterCard ___ Discover ___ American Express

Account Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____
Month Year

CVV: _____

Card Billing Address: _____
Address 1

_____
Address 2

_____ _____ _____
City State Zip

_____ _____
Cardholder Signature Date