

## **QUALIFICATIONS OF THERAPIST**

Please take this time to note the following, which has been documented, to better acquaint you with my background as well as assist you in understanding our professional relationship.

Mary DeGuilio is a Licensed Professional Counselor (LPC). She holds a Masters degree in Professional Counseling from Ottawa University with a focus on marriage, family and addictions counseling. Mary's clinical orientation emphasizes a strengths-based, client-centered approach to change. She exhibits a genuine belief that individuals possess the capacity to create positive life changes and improve interpersonal relationships. Mary's broad-based experience enables her to effectively assist adults, couples, families, and children cope with anxiety, depression, family and relationship issues, grief and loss, substance abuse and other addictions, trauma, career change and job stress, and other affective and cognitive disorders. Mary is an active member of the American Counseling Association.

## **EMERGENCY CONTACT**

If you have an emergency after regular office hours please call our emergency answering service at **480-303-1070**. The service will attempt to reach me at home. If I am not available, one of my colleagues will be called. If for some reason the answering service cannot reach someone quickly, you can call the Maricopa County Crisis Line at 602-222-9444, or any other hospital of your choice.

## **CLIENT RIGHTS**

- You have the right to decide not to receive counseling from me. If you wish, I can provide you with the names of other qualified therapists.
- You have the right to end therapy at any time.
- You have the right to ask questions about the procedures used during therapy.
- You have the right to ask questions about the counseling techniques and to prevent the use of certain therapeutic techniques if you feel uncertain of them.
- You have the right to participate in setting goals and evaluating progress toward meeting them.
- You have the right to have all that you say treated confidentially and be informed of the State Law placing limitations on confidentiality in the counseling relationship. Under certain circumstances, I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) If you threaten grave bodily harm or death to self or another person, I am required by law to inform the intended victim and appropriate law enforcement agencies; (b) If a court of law issues a subpoena; (c) If you are in therapy or being tested by order of a court of law, the results of the treatment or the treatment or tests must be revealed to the court; (d) If you have given me information concerning non-accidental injury and neglect to minors or incompetent adults.

## **CLIENT RESPONSIBILITIES**

- Set and keep appointments with your therapist. Appointments scheduled and **cancelled without at least 24-hour notice are subject to full charge.**
- Pay your fees in accordance with the arrangement you have pre-established with your therapist.
- Help plan your therapy goals.
- Keep Ms. DeGuilio informed of your progress toward meeting your goals.
- Inform Ms. DeGuilio of any problems you have which may have an effect on your progress or which may be potentially harmful to yourself or others.

( CONTINUED ON NEXT PAGE )

## **RISKS AND BENEFITS OF THERAPY**

Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear, anger, anxiety, depression, frustration, loneliness or helplessness.

The benefits from therapy may be that you will be better able to handle or cope with your family or other social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to a greater maturity and growth as a person.

You should know that a therapist is not a physician and cannot prescribe medication or perform any medical procedures. If medical treatment is indicated, I will recommend a physician for you, or you can choose any physician whom you wish to see.

You should also understand that I cannot guarantee that the goals of therapy will be attained; however, I will offer to do my part as your therapist to apply all the knowledge and resources that I have to help you attain your therapy goals.

If you have any questions or concerns about anything that occurs in this office, please let me know. My main objective is to provide you with productive visits.

**By my signature below, I consent to receive therapy from Mary DeGuilio and acknowledge that I have read the above information and understand it.**

\_\_\_\_\_  
**Client's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client's Signature**

\_\_\_\_\_  
**Date**

# Family Psychology Associates

14045 North 7th Street Suite 4 Phoenix, Arizona 85022 Phone 602.993.4595 Fax 602.993.7440

Pat Huish, Ph.D. | Joalene Whitmer, M.C., LPC | Mary DeGuilio, M.C., LPC | Richard Ruff, M.C.

## SECTION A - CLIENT OR GUARDIAN of MINOR INFORMATION:

**If treatment is for a minor, the legal guardian should complete Section A with his/her information and put an \* next to the child's name in Section B.**

Today's Date: \_\_\_\_\_

Male  Female

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Birthplace: \_\_\_\_\_ SS #: \_\_\_\_\_

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

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

Occupation: \_\_\_\_\_ Education(years): \_\_\_\_\_ E-mail address: \_\_\_\_\_

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

## SPOUSE INFORMATION:

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Birthplace: \_\_\_\_\_ SS #: \_\_\_\_\_

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

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

Occupation: \_\_\_\_\_ Education: (years) \_\_\_\_\_ E-mail address: \_\_\_\_\_

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

**Marital Status:**  Married  Single  Divorced  Widowed  Separated

Date of Marriage(s) \_\_\_\_\_ Date of Divorce(s) \_\_\_\_\_

## SECTION B - CHILDREN: (if a child is the client please put \* by each child's name)

NAME	BIRTH DATE	AGE	LIVING WITH YOU	GRADE	SCHOOL

## SECTION C - ADDITIONAL INFORMATION:

**Emergency Contact Person:** Full name \_\_\_\_\_ Phone # \_\_\_\_\_

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

**Family Physician:** \_\_\_\_\_ Phone # \_\_\_\_\_

**Religious Preference (if any):** \_\_\_\_\_

**HISTORY:**

List any medications patient is currently taking: \_\_\_\_\_

What is the reason for this visit? (Chief Complaint):  
\_\_\_\_\_  
\_\_\_\_\_

What do you wish to change or accomplish by seeking counseling at this time?  
\_\_\_\_\_

Are you or have you ever been suicidal?                      YES    NO

Have you ever been in therapy before?                      YES    NO

If yes, please state where and when:  
\_\_\_\_\_  
\_\_\_\_\_

Do you drink alcoholic beverages?                      YES    NO

If so, how much per week? \_\_\_\_\_

Have you ever been told you have a drinking problem?    YES    NO

If so, by whom? \_\_\_\_\_

Are you or have you ever been treated for any mental illnesses?    YES    NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Are you presently in good general health?                      YES    NO

Are you currently being treated for any physical illnesses?                      YES    NO

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have any family history of the following mental or emotional challenges?

\_\_\_Depression    \_\_\_Schizophrenia    \_\_\_Anxiety    \_\_\_Anger    \_\_\_Phobias

Comments: \_\_\_\_\_

Is there anything else you feel is necessary for the practitioner to know regarding your situation?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONTACT INFORMATION:**

Occasionally we may have a need to contact you outside your office visits. Please check the boxes of the ways we may contact you:

- Home Phone     Cell Phone     Work Phone     Email

Permission to leave a message with name): \_\_\_\_\_

Do **NOT** leave a message at: \_\_\_\_\_

Explain \_\_\_\_\_

## PRIMARY INSURANCE

It is important that you call your insurance to verify the details of your “**out-patient behavioral health**” coverage. Sometimes, the coverage details are different than medical coverage. Since any charges not covered by your insurance are your responsibility, we strongly recommend that you call your insurance company prior to your first visit to ensure that the information you enter below is complete and accurate.

**If you are not using insurance, please write “no insurance” below.**

Insurance Company Name: \_\_\_\_\_

Insured's name: \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Employer \_\_\_\_\_

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Is this provider covered as an “**in-network**” provider or as an “**out-of-network**” provider?: \_\_\_\_\_

What is your Deductible?: \_\_\_\_\_ Is the Deductible met?: \_\_\_\_\_

How many visits are allowed per year?: \_\_\_\_\_

What is your Co-Pay / Co-insurance?: \_\_\_\_\_

Is an Authorization needed?: \_\_\_\_\_ Obtained?: \_\_\_\_\_ Authorization Number: \_\_\_\_\_

Billing Address for claims: \_\_\_\_\_

*I authorize the release of any necessary information to my insurance carrier or other agent preparing claims for payment of my office charges. I also request and authorize payment of benefits be paid directly to the counselor or party who accepts assignment/participates. If assignment is not accepted, I understand that I am responsible for the full amount charged for services. I understand I am responsible for paying my deductible and the portion of each session not covered by my insurance.*

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

## IMPORTANT INFORMATION CONCERNING INSURANCE

If you have insurance, we will help you receive maximum benefits available through your insurance. However, we cannot guarantee coverage or payment. Benefits and descriptions of coverage are provided as a courtesy only and we cannot guarantee their accuracy. The benefits are an agreement between the employer group (or individual party) and the health benefit firm that administers the policy – *we are not a party to this contract*. Submitting insurance claims is a courtesy that we extend to our clients - all charges are your responsibility from the date of service.

You are responsible for your deductible and co-pays/co-insurance not covered by your insurance. These payments are due at the time of your visit.

Communication is essential. If any of the above policies are unclear to you, please direct your inquiries to the office manager. Your satisfaction is very important to us! If you feel that there are extenuating circumstances in your case, please immediately bring these to the attention of our office manager. If you don't tell us, we won't know.

I certify that I have read and do understand these policies. Furthermore, I understand that I do assume full financial responsibility for my care should my insurance carrier decline payment for services rendered at Family Psychology Associates.

**Client (or Responsible Party) Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FINANCIAL POLICY**

**ALL CLIENTS:**

- **Payment in full is due at the time services are rendered.** (unless other arrangements have been made with counselor)
- **A 1.5% per month (18 % annual) service charge may be added to all delinquent accounts.**
- **Any account greater than 30 days delinquent may be turned over to a licensed collection agency without notice.**
- **Collection fees that are charged by the agency on the outstanding balance are the client's responsibility.**
- **Any legal and/or attorney's fees incurred in collection of outstanding accounts will be assessed against the delinquent account and are the client's responsibility.**

I/we have read the above and agree to the terms specified. I/we agree that I/we will be held personally responsible for payment of any services rendered by this office I/we understand that all payments not made when due may bear interest at the rate of 1.5% per month on the unpaid balance. I/we am fully aware that if I/we do not pay for these services that this office may process the unpaid balance through the legal assistance of a collection agency. I/we will be liable for all collections costs, including agency and attorney fees, as well as court costs incurred and permitted by laws governing this transaction.

X \_\_\_\_\_  
SIGNATURE OF CLIENT AND/OR RESPONSIBLE PARTY DATE

X \_\_\_\_\_  
SIGNATURE OF CLIENT AND/OR RESPONSIBLE PARTY DATE

**PAYMENT INFORMATION:**

Who will be responsible for payment of your account ( Please circle one)

SELF                      SPOUSE                      MOTHER                      FATHER                      OTHER

Name of responsible person: \_\_\_\_\_ SS#: \_\_\_\_\_

Address of responsible person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer of responsible person: \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

**MISSED APPOINTMENTS**

If you are unable to keep a scheduled appointment, we **require you to cancel 24 hours in advance, so that someone else may be offered that time. Our policy is to charge for missed appointments at the rate of a normal office visit. These will be billed to the client and prompt payment is expected. This policy is exclusive of any applicable health insurance. I have read and understand the policy regarding missed appointments and late cancellations.**

SIGNED \_\_\_\_\_  
CLIENT AND/OR RESPONSIBLE PARTY

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## **INFORMED CONSENT REGARDING MISSED APPOINTMENTS:**

As an addendum to the information provided with intake, this is a reminder that you are responsible to keep scheduled appointments. If you cannot keep a scheduled appointment, please let us know 24 hours in advance so we can allow someone else to have that time slot. We almost always have clients on a waiting list, waiting for an available time. You can call our main number anytime and leave a voice mail message letting us know you cannot keep your appointment.

Please note that we do not bill insurance for missed appointments. If you fail to keep a scheduled appointment and do not cancel with at least 24 hours notice, we require you to pay the full rate for that missed appointment before future appointments can be scheduled.

If a personal emergency prevents you from canceling with at least 24 hours notice, please call us as soon as possible and let us know the nature of the emergency.

We apologize for any hardship this creates for you. We value you as our client and want to provide you, and our other clients, with the services you need. When appointments are missed, that is time that could have been given to someone else in need.

We appreciate your understanding. Please sign below to acknowledge you have been informed of our policy regarding this matter.

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

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## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Family Psychology Associates, concerning how the use or disclosure of Protected Health Information will be handled by the practice.

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Print Name of Patient or Personal Representative**

\_\_\_\_\_  
**Description of Personal Representative Authority**

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## CONSENT FOR TREATMENT OF A MINOR:

<p><b>If treatment is for a minor</b>, please also complete this consent form. This form must be complete by the legal guardian of the minor.</p>
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I, \_\_\_\_\_, hereby grant Family Psychology Associates permission to provide outpatient behavioral services to my child, \_\_\_\_\_.

I understand that any information given to Family Psychology Associates will not be shared with anyone without written permission, except where required by law (for example: danger to self, or others, or suspected child abuse). I have been informed of my rights as a patient of Family Psychology Associates. I understand I may withdraw my consent at any time by notifying Family Psychology Associates in writing.

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent / Legal Guardian of Minor**