Marie Haddox, Ph.D.

1760 E. Boston St. Ste. 102
Gilbert, Arizona 85295
480.782.0113

CLIENT INFORMATION

CLIENT NAME: _____ _____
Last First Date of Birth Age

PARTNER NAME: _____ _____
Last First Date of Birth Age

PARENTS' NAMES (for minor child) _____

ADDRESS: _____

PHONE: _____
Home Work Cell

WHICH NUMBER MAY WE USE TO CONTACT YOU? _____

E-MAIL ADDRESS: _____

EMPLOYER: _____ GRADE: _____

OCCUPATION: _____ SCHOOL: _____

FINANCIAL RESPONSIBILITY

The client or responsible party is responsible for payment of professional services. Signature below certifies client/responsible party acknowledges Dr. Haddox does not accept ANY health insurance and will not submit claims for reimbursement. Credit card information will be kept on file and charged only for No Show fees, Late Cancel fees, or unpaid balances that the client has not paid in full at the time of services.

CREDIT CARD: _____ ACCT #: _____CCV #:_____ EXP: ____/____

Signature: _____ Date: _____

PERSONAL INFORMATION

REASON FOR COUNSELING: _____

_____

REFERRED BY: _____

PREVIOUS COUNSELING:_____

_____

CURRENT MEDICATION: _____

_____

_____

MEDICAL PROBLEMS/CONCERNS: _____

_____

_____

PROBLEM CHECKLIST *(Please circle all that apply):*

Nervousness
Shyness
Drug use
Anger
Sleep
Anxiety
Legal issues
Loss of energy
Loneliness
Education
Job difficulties
Lack of motivation
Impulsivity
Stomach problems
PMS
Pornography
Masturbation

Irritable bowel
Alcohol use
Stress
Social difficulties
Lack of friends
Excessive fatigue
Poor decision-making
Depressed mood
Headaches
Memory loss
Feelings of inferiority
Career Uncertainties
Nightmares
Loss of appetite
Excessive appetite
Unusual fears
Excessive fears

Excessive worry
Obsessive thoughts
Racing thoughts
Suicidal thoughts
Unhappiness
Relationship issues
Weight gain
Weight loss
Irritability
Muscle tension
Restlessness
Hopelessness
Low self-esteem
Tearfulness
Poor concentration
Poor physical health
Sexual difficulties

HIPAA INFORMATION AND CONSENT FOR TREATMENT

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If your therapist needs to communicate with another about your case, you must give written permission to do so. The only exception to this is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm, or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide or homicide.

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

INFORMED CONSENT

Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While we will use our best efforts to assist you, the nature of psychological services is that there can be no assurances of results, and no promises can be made regarding the outcome of any services provides. You should question the rationale of any services, intervention, and discussion if these seem unclear to you.

FEES/PAYMENT

Our fees are based on 60 minute sessions and double sessions are 100 minutes. Longer or shorter sessions are prorated accordingly**. After-hour phone sessions will be billed at a fee of $45 per 15 min. increments.** Payment is expected at the time services are rendered, by cash, check or credit. Psychological or court reports will not be issued until full payment for services is received. Additional fees may apply for letters/completion of forms.

MISSED APPOINTMENTS

If you are unable to keep an appointment, please notify the therapist immediately. If an appointment is cancelled or missed **without 24 hours prior notice, you will be billed for the missed session at the rate of $75. Third and subsequent late cancellations will be billed the full fee. These fees may be charged to the credit card on file.**

INITIAL _____

RESPONSIBILITY

The client (or responsible party) is considered responsible for payment of professional services. Fees not paid within 30 days from the date of billing will be subject to an interest charge of 10% of the outstanding bill and the credit card on file will be charged for total balance due.

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize my therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. I acknowledge that I have both read and understood all terms and information contained herein.

_____ _____

Client/Spouse or Partner Signatures
OR
Parent/Guardian Signature

Date