Marie Haddox, Ph.D.
428 S. Gilbert Rd. Ste. 105
Gilbert, Arizona 85296

SPECTRUM
COUNSELING

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480-782-0113

CLIENT INFORMATION

CLIENT NAME: _______________________________________ _________________________________
Last First Date of Birth Age

PARTNER'S 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: _____________________________________ OCCUPATION: _____________________________

SCHOOL: ____ GRADE:___________________

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 #: ___________________________________ CVC #: _________ EXP: ___/___

SIGNATURE: ____ DATE: _________________

PERSONAL INFORMATION

REASON FOR COUNSELING: ____

____

REFERRED BY: ____

PREVIOUS COUNSELING: ____

____

CURRENT MEDICATIONS/REASONS:____

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MEDICAL PROBLEMS/CONCERNS:____

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

Nervousness	Pornography	Excessive Worry	Restlessness
Shyness	Masturbation	Loss of Appetite	Hopelessness
Drug Use	Irritable Bowel	Excessive Appetite	Low self-esteem
Anger	Alcohol Use	Unusual Fears	Tearfulness
Sleep	Stress	Excessive Fears	Irritability
Anxiety	Social Difficulties	Obsessive Thoughts	Memory Loss
Legal Issues	Lack of Friends	Racing Thoughts	Weight Gain
Loss of Energy	Excessive Fatigue	Suicidal Thoughts	Weight Loss
Loneliness	Poor Decision-Making	Unhappiness	Muscle Tension
Education	Depressed Mood	Relationship Issues	Impulsivity
Job Difficulties	Poor Concentration	Sexual Difficulties	PMS
Lack of Motivation	Poor Physical Health	Feelings of Inferiority	Nightmares
Stomach problems	Career Uncertainties		

HIPPA 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 (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA 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. HIPPA 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 assurance of results, and no promises can be made regarding the outcome of any services provided. 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. Longer phone sessions are prorated accordingly. 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 without 24-hour notice, you will be billed for the missed session at the rate of $75. Third and subsequent late cancelations, as well as appointments that are missed without ANY notice, 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 Date

Parent/Guardian Signatures