Metro NBI
Metropolitan Neuro Behavioral Institute

Consent for Treatment (Pg. 1 of 4)

The Nature of Services Provided: This office and the therapists provide psychotherapy to clients for the purpose of helping individuals come to terms with, relieve, and/or overcome personal difficulties, mental illness, and other obstacles to personal growth by conducting individual, couples, family, and group therapy.

Therapeutic Techniques: The psychotherapeutic techniques employed by the therapists include but are not limited to: client centered therapy, cognitive therapy, schema therapy, Eye-movement and desensitization therapy (EMDR), dialectical behavior therapy (DBT), present moment awareness therapy (mindfulness), meditation, Gottman's method couples therapy, behavioral activation techniques, existential therapy, Animal Assisted Therapy and other therapies as will be explained by your therapist.

Procedures: Therapy typically consists of individual sessions lasting 50 minutes, which are sometimes accompanied by group sessions lasting two hours on a weekly basis. You can expect that your therapist will receive you at the waiting room door within the first ten-to-fifteen-minutes of the hour. Your therapist can typically be reached during normal work hours at 480-461-44431 #8. In the event of an emergency, please dial 911, call the Crisis Line (602)222-9444, or go to the nearest ED. Our therapists reserve the right to not conduct the therapy session if payment is not provided in full. The client is expected to inform the therapist when he/she intends to cancel their session at least **48 hours in advance.** The client will be billed for any sessions that are not canceled at least 48 hours in advance.

Continuation of Services Upon Incapacitation: If your therapist becomes ill, has an emergency, or other situation which prevents therapy from occurring normally, Metro NBI staff, if possible, make other arrangements to ensure the continuation of service. If the incapacitation is severe, a staff member appointed by your therapist will arrange a time to meet with you to consider and plan for the continuation of therapy.

Tests and Reports: Any assessment tests and reports will be explained fully and any concerns you may have will be discussed fully. Unless otherwise mandated by law, you will have access to all results and reports placed in your file and the opportunity for additional discussion regarding this information as you deem necessary. Currently, certain types of assessment instruments can only be given and interpreted by licensed psychologists or under the supervision of licensed psychologists. You will either be referred to the appropriate professional or advised when interpretations of reports require additional expertise or licensure.

Fees: Individual clients will be asked to pay a fee that is in accordance to the company policy. This fee is $125 for a 50-minute session. Bulk payment packages are available. Your therapist reserves the right to refuse service because of billing irregularities or because of a lack of agreement for service. Fees may be negotiable as therapy progresses and may change as the financial situation of the client changes. This will be discussed, and the client will be given advanced notice of any changes in fees.

Contact via Phone: Please check yes or no at the end of each statement:

1.) I allow my therapist to leave a message on my voicemail stating their name, phone number, and the purpose of the call.

☐ **YES** ☐ **NO**

2.) If a family member or another person answer my phone, I allow my therapist to leave a message with this person with their name, phone number, and purpose of the call.

☐ **YES** ☐ **NO**

Contact via Email or Text Message: Emails and texts are inherently insecure, and confidentiality cannot be guaranteed. Please check yes or no at the end of each statement:

1.) I allow my therapist to send an email or text to me or reply to an email or text I have sent to them and release my therapist from any guarantee of confidentiality in email communications.

☐ **YES** ☐ **NO (If answered no, it is understood that any return email or text to the client in the future will have minimal information and will include a request that all future communications out of session are conducted by phone or letter.)**

I,_____acknowledge receipt of a copy of the above "Consent for Treatment" and I am aware of my rights, the limits of confidentiality, the risks/ limitations/ and benefits of treatment, and my treatment goals and methods (see attached treatment plan). I understand that this consent for treatment applies to other therapists and medication providers affiliated with Metro NBI other than my primary individual therapist for the purposes of attending group, family or couple's therapy.

Signature of Client/Guardian	Date	Witness/Therapist	Date

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Consent for Treatment (Pg. 2 of 4)

Expectations Regarding Your Participation in Treatment: *We believe in recovery models of care.* It is expected that you will be an active participant in all phases of your treatment to include setting goals, monitoring progress, discussing issues or problems with the therapeutic relationship, and completing homework. If you show repeated lack of participation in your therapeutic process and it is mutually agreed that the therapy process is not assisting you, therapy may end. The therapist reserves the right to end therapy if the client shows repeated disregard for actively participating in therapy and numerous warnings have been given the client regarding this issue.

The Right to Refuse Therapeutic Services: The client has the right to refuse any therapeutic suggestion or modality that the client feels would not be helpful. If this occurs, the client's symptoms of anxiety, depression, and other mental health issues may continue unabated, become worse, or even become better over time. The therapist reserves the right to terminate therapy or refer the client to another mental health professional if the client does not want to engage in certain therapeutic practices, if the client is not benefiting from therapy, or if the therapist believes the client would be better served by another mental health professional's expertise. Adequate time to discuss such an option will be provided to the client before such a change occurs.

Understanding Your Diagnosis: It is important that the client understands any psychological diagnosis made their therapist at any time during therapy. The therapist will advise you of your diagnosis and provide time to discuss in detail the implications of this diagnosis and the treatment options. The ramifications of diagnosis and the fact that a diagnosis may become a permanent part of your file will also be discussed.

Cultural Sensitivity and Use of Clear Language: Your therapist will make every effort to be sensitive to cultural, gender, and racial issues as they pertain to the therapeutic interaction between the therapist and the client. It is quite possible that the client may need to provide additional information to the therapist regarding cultural norms or other related concerns if difficulty in understanding occurs. Your therapist will also try to gain additional cultural knowledge when required from other sources. There will be the expectation that all aspects of the therapeutic process will be explained clearly to the satisfaction of the client. In the event of a language barrier an interpreter or other services will be provided when possible.

Inability to Give Consent: Your therapist will attempt to obtain informed consent with every client, but in those cases where individuals are unable to provide informed consent due to incapacitation, every effort will be made to include the client in decision making as appropriate, and the therapist will act in the best interests of the client. Your therapist is also aware of the need to balance the client's need to make choices with their capacity to give consent, and the legal rights of families.

Respecting Your Values and Beliefs: The client values, beliefs, attitudes, and behaviors will be heard and respected by this therapist. In those cases, in which critical values or beliefs are contrary to your therapist's, it is expected that this will be discussed fully and resolved if possible. If there is an irresolvable clash in values or beliefs or if your therapist feels that your perspectives are risky or place the client in danger, this will also be discussed. The therapist may refer the client to another therapist when there are irresolvable disagreements about values and beliefs. The therapist will make every effort to not impose their value system on the client or make it apparent when they believe that the client may benefit from examining or changing their values.

Meeting Outside of the Therapeutic Session and Avoiding Dual Roles: It is important for the safety of the client to understand that the therapist cannot have any kind of personal relationship with the client outside of the professional therapeutic relationship which occurs during the normal psychotherapy hours within the therapist's office. Typically, this means that the therapist will have no personal contact with the client outside of the office except for phone coaching calls, coaching tests, or perhaps short conversations in a public place as a result of a chance meeting. Further, in order to protect the client's confidentiality, the therapist will not initiate a greeting with the client in a public place but only return the greeting if it is initiated by the client. If a short exchange occurs, no information will be provided by the therapist which identifies how or why the therapist knows the client to protect the client's confidentiality.

Issues Concerning Clients Offering Therapists Gifts: On occasion, clients wish to offer therapists gifts of small monetary value at the end of therapy. Although this is not inherently problematic, it is neither encouraged nor expected. If a gift is offered by clients while in ongoing therapy, the therapist will refuse any gift of significant value or will refuse any gift that is contrary to the goals of therapy. Additionally, the offer of the gift may become an issue which is discussed for therapeutic purposes.

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_____	_____	_____	_____
Signature of Client/Guardian	Date	Signature of Therapist/Witness	Date

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Consent for Treatment (Pg. 3 of 4)

Your Counseling Record: The client has the right at any time to ask for a copy of their medical record. A copy of a summary of your medical record will be provided within four weeks of the request unless the specifically needing the whole chart. The psychotherapy note will not be released except through a court order. Your records will be kept on file for seven years after termination of therapy. Thereafter, they will be securely disposed of and no longer be available. You may receive a copy of your records by calling the office (480)464-4431option #5.

Note: *If a couple has had counseling together, and both parties have not signed a release regarding the record, issues related to the non-releasing party will be blacked out. Your records will be maintained at this office during your active counseling and remain secured upon closure of your file.*

Determining the Length of Therapy: The length of therapy will differ by client and diagnosis. There are no hard and fast rules regarding the length of therapy. Therapy will continue if it is beneficial for the client and the therapist is able to provide therapeutic services which meet the needs and goals of the client.

Disputes, Grievances, Complaints: We ask all clients to discuss any complaints, grievances, and mistreatment with their therapist first. In the event that the client feels mistreated or that he or she has a grievance which has not adequately been answered by the therapist, or supervising therapist he or she is encouraged to file a dispute or grievance with Dr. Lauro Amezcua-Patino, MD, the owner of this practice or the Arizona Board of Behavioral Health. These addresses and phone numbers will be provided upon request. The hope is that the grievance can be discussed and resolved before any formal complaints are made.

Purpose of Psychotherapeutic Treatment: To relieve emotional distress and to help people with mental illness change their attitudes and/or behavior.

Methods and Goals: This is an ongoing process between you and your therapist. Together we decide what you want to accomplish and how best, given your personality, preferences, and issues, to treat and relieve the symptoms you are experiencing. Generally, this refers to supportive, behavioral, and cognitive methods of therapy.

Benefits of Treatment: To reduce suffering related to anxiety, panic, obsession, phobias, depression, post-traumatic stress disorder, personality disorders, bipolar, or other adjustments to life issues.

Limitations of Treatment: Therapy is a process and not every match between therapist and client is productive for the client. If you find you are not making progress and you would like to change therapists, please discuss this with your therapist. Also, treatment often improves situations but does not offer a panacea for life. You must participate fully, or progress can be stalled or fail to move forward at all. And, in some cases, even with the best of treatment improvement is minimal. If no progress is evident, your therapist may refer you to see someone else.

Potential Risks of Treatment: Treatment can be upsetting to you and those around you as you confront issues, begin to change, and grow. As in any form of "treatment" there are risks of a treatment working for one person and not another. Also, as therapy is often a process you can uncover issues that you did not expect to and thus the pain and feelings related to those issues can be quite difficult to process. This is part of the therapeutic process, but you may feel "worse" before you feel "better". Finally, friends and family are not always supportive of growth and change a person makes and this can result in decisions you make to change relationships in your life. While it is a sign of growth, again therapy can cause pain and change.

Limits of Confidentiality: Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

- The client threatens suicide.
- The client threatens harm to another person(s), including murder, assault, or other physical harm.
- The client is a minor (under 18) and reports child abuse, including but not limited to, physical beatings and sexual abuse.
- The client reports abuse of the elderly.
- The client reports abuse of any minor (under 18).
- The client reports sexual exploitation by a therapist.
- Court ordered or subpoena of records by a judge. State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies. Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

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_____	_____	_____	_____
Signature of Client/Guardian	Date	initials of Witness/Therapist	Date

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Consent for Treatment (Pg. 4 of 4)

Client's Bill of Rights: As a client, you have the right to:

- Receive respectful treatment that will be helpful to you.
- Receive a treatment or end treatment without obligation or harassment.
- A safe environment, free from sexual, physical, and emotional abuse.
- Report unethical or illegal behavior by a therapist.
- Ask questions about your therapy.
- Request and receive full information about the therapist's professional capabilities including certification, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, methods of payment, insurance reimbursement, number of sessions, substitutions (in case of vacation and emergencies), and cancellation policies before beginning therapy.
- Refuse electronic recording, but you may request it if you wish.
- Refuse to answer any questions or disclose any information you choose not to reveal.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Clinical Supervision is provided for non-independent licensed therapists. You have the right to talk to the Clinical Supervisor if a concern cannot be solved through your therapist.
- Request a summary of your file, including the diagnosis, your progress, and type of treatment.
- Request the transfer of a copy of your file to any therapist or agency you choose.
- Receive a second opinion at any time about your therapy or therapist's methods.
- Request that the therapist inform you of your progress.
- Refuse any treatment or referral offered.

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_____	_____	_____	_____
Signature of Client/Guardian	Date	initials of Witness	Date

HIPAA NOTICE FORM (Pg. 1 of 2)

THIS FORM DESCRIBES THE CONFIDENTIALITY OF YOUR MEDICAL RECORDS, HOW THE INFORMATION IS USED, YOUR RIGHTS, AND HOW YOU MAY OBTAIN THIS INFORMATION

Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place. The contents of the material disclosed to me in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us, and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this office for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this therapist not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, they may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a healthcare professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients, or guardians of incapacitated adults, have the right to access the client's records.

Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to provide payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the timeframe, and the name of the clinic or collection source.

HIPAA NOTICE FORM (Pg. 2 of 2)

THIS FORM DESCRIBES THE CONFIDENTIALITY OF YOUR MEDICAL RECORDS, HOW THE INFORMATION IS USED, YOUR RIGHTS, AND HOW YOU MAY OBTAIN THIS INFORMATION

Consultations with other professionals in order to provide the best possible treatment are also provisional excluded. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the office or by outside sources specializing in (and held accountable for) such procedures. In the event in which the mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify the office in writing where we may reach you by phone and how you would like me to identify myself. For example, you might request that when we phone you at home or work, we do not say the name of the office or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to me (below), Metro NBI staff will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the office. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the office (to protect confidentiality). If we reach an answering machine or voicemail, we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. You have the right to cancel a release of information by providing me a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing. You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made in writing. You have the right to disagree with the medical records in our files. You may request that this information is changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file. You have the right to know what information in your record has been provided to whom. Request this in writing. If you desire a written copy of this notice you may obtain it by requesting, it from medical records of Metro NBI staff.

Complaints

If you have any complaints or questions regarding these procedures, please contact the Metro NBI main office at 480-464-4431 nurses' line or ask to leave a message for the clinical supervisor or Dr. Amezcua-Patino. If your complaint is not resolved after contacting Dr. Amezcua-Patino to your satisfaction you may submit a complaint to the Secretary of the U.S. Dept. of Health and Human Services at 200 Independence Ave., S.W.; Washington, D.C. 20201.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print)_____ Date:__/__/__

Signature_____ Date:__/__/__

Metro NBI
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Initial Focus of Treatment

Client Name	

	Goals		Goals
☐	Reduce/eliminate depression	☐	Reduce/eliminate guilt or shame
☐	Reduce/eliminate anxiety or panic attacks	☐	Reduce/eliminate obsessive thought
☐	Reduce/eliminate feelings of hopelessness	☐	Reduce/eliminate compulsive behavior
☐	Improve body image	☐	Learn to make friends/develop support network
☐	Learn decision-making and problem-solving skills	☐	Reduce/eliminate feeling disconnected or isolated
☐	Learn to negotiate and compromise	☐	Learn to slow racing thoughts
☐	Learn assertiveness or other communication skills	☐	Reduce/eliminate dependency
☐	Reduce aggression	☐	Reduce sensitivity to criticism
☐	Reduce passivity	☐	Learn to set boundaries
☐	Reduce/eliminate self-injury	☐	Learn to set and accomplish goals
☐	Reduce/eliminate mood swings	☐	Explore spirituality
☐	Increase ability to handle frustration or irritability	☐	Increase focus, attention, concentration
☐	Reduce anger and irritability	☐	Cope with pain or physical disability
☐	Reduce fears about being alone or abandoned	☐	Combat addictive behaviors in self
☐	Decide about divorce/separation	☐	Address addictive behaviors in a loved one
☐	Deal with the impact of divorce/separation	☐	Explore sexuality/orientation
☐	Heal from an abusive childhood	☐	Recover from sexual abuse
☐	Learn to identify, tolerate, and express feelings	☐	Other:

Review Date	

Aftercare Plan	

I understand the goals and methods of my treatment plan and understand that I can freely disagree with my counselor at any time and choose to not act on suggestions offered by my therapist:

_____ _____ _____ _____

Signature of Client/Guardian Date Signature of Therapist Date

Metro NBI
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On-Going Treatment Plan Review

Client Name	

	Goals		Goals
	Reduce/eliminate depression		Reduce/eliminate guilt or shame
	Reduce/eliminate anxiety or panic attacks		Reduce/eliminate obsessive thought
	Reduce/eliminate feelings of hopelessness		Reduce/eliminate compulsive behavior
	Improve body image		Learn to make friends/develop support network
	Learn decision-making and problem-solving skills		Reduce/eliminate feeling disconnected or isolated
	Learn to negotiate and compromise		Learn to slow racing thoughts
	Learn assertiveness or other communication skills		Reduce/eliminate dependency
	Reduce aggression		Reduce sensitivity to criticism
	Reduce passivity		Learn to set boundaries
	Reduce/eliminate self-injury		Learn to set and accomplish goals
	Reduce/eliminate mood swings		Explore spirituality
	Increase ability to handle frustration or irritability		Increase focus, attention, concentration
	Reduce anger and irritability		Cope with pain or physical disability
	Reduce fears about being alone or abandoned		Combat addictive behaviors in self
	Decide about divorce/separation		Address addictive behaviors in a loved one
	Deal with the impact of divorce/separation		Explore sexuality/orientation
	Heal from an abusive childhood		Recover from sexual abuse
	Learn to identify, tolerate, and express feelings		Other:

Review Date	

Aftercare Plan	

I understand the goals and methods of my treatment plan and understand that I can freely disagree with my counselor at any time and choose to not act on suggestions offered by my therapist:

_____ _____ _____ _____

Signature of Client/Guardian Date Signature of Therapist Date

Metropolitan Neuro Behavioral Institute Payment Policy

All payment for psychotherapy is generally due ***on the same day when scheduling the appointment,*** however an exception for payment on day of service or the day before the service if paying by credit card will be considered if financially needed. The therapists accept cash, personal checks and credit/debit cards.

Outstanding balances will not be carried forward unless the client has made a previous arrangement with their therapist.

All clients are required to leave a credit card on file to address missed session/late cancellation fees and/or to pay their session fee if that is desired. Clients may request receipts via the form of a "Superbill" for reimbursement or personal purposes at any time.

I,_____, hereby authorize Metro NBI to charge my credit card as payment for my individual, family and/or group sessions on the same day the service is rendered for the amount or balance due and/or for missed/late cancel fees. If I do not wish to pay my session fee with my card kept on file, I understand a card will still be kept on file to be used for any missed/late cancel session fees incurred per the policy outlined in the Metro NBI cancellation policy.

Type of Card: Visa MasterCard Amex Discover

Credit Card Number: _____

Expiration Month & Year: _____

CSC (three digits on back of card)_____

Name of Cardholder: _____

Credit Card Billing Address: _____
(if different than one provided)

Authorized Signature of Cardholder_____

I acknowledge the payment policy described above and assume full responsibility for all charges. I agree to honor and abide by the terms of payment.

Client/Guardian Signature:_____ Date_____

Metropolitan Neuro Behavioral Institute Cancellation Policy

If you fail to cancel a scheduled appointment within **48-hour notice**, we cannot use this time for another client. This is a loss for all parties concerned. Therefore, you will be billed $75.00 for the missed appointment.

With the client's signature, it is understood by the client that a $75.00 fee is automatically charged for missed appointments/no shows and cancellations with less than a **48-hour notice**. The only exception to this is when a sudden serious illness has occurred (requiring a doctor's appointment or hospitalization and documentation to support this) or there has been an extreme emergency. Extreme emergencies must be crisis type events that are unexpected, unavoidable and unforeseeable. Car difficulties or issues with obtaining childcare do not constitute an extreme emergency. Your therapist reserves the right to modify this cancellation policy to hours' notice based on the circumstances of the late cancellation. Further, Monday appointments must be cancelled by the end of business day on Friday at 3:00 PM. Cancelling via voicemail or email on Saturday and Sunday *will be* considered a late cancellation because we do not have staff available on those days to receive your call or read your email and then fill that cancelled session time with another client.

Thank you for your consideration regarding this important matter.

Client/Guardian
Signature_____

Date_____