Carolyn Flynn, MC, LPC
http://CarolynFlynn.org
480-395-1427

NEW PATIENT PACKET
Adult Therapy

Dear Patient,

Please read, complete, and sign the accompanying papers to the best of your ability. (Forms take approximately 15-minutes to complete.) We will go over the documents you signed during your first session. Completion of required paperwork is part of the initial session.

The initial therapy session is an information gathering session where you will have the opportunity to discuss your current concerns, and share some brief medical, psychiatric, and family history. We will also discuss policies, procedures, and counseling limitations and expectations.

Payment is due at the beginning of your appointment. You will receive a receipt for payment that you may submit to your health insurance for reimbursement of out-of-network counseling services or keep for your tax records. Mental health services may be a tax-deductible medical expense. I look forward to spending some time with you and your family. Thank you for completing the necessary patient information forms.

Sincerely,

Carolyn Flynn, MC, LPC
Licensed Professional Counselor

Carolyn Flynn, MC, LPC
480-395-1427
Client_____

Date_____

CONFIDENITAL REGISTRATION FORM
Adult Therapy
(please print clearly)

Client name _____

Client SS# _____ DOB _____ Age _____ Gender _____

Spouse/Significant Other _____ DOB _____ Age _____

Address _____ City _____ State ____ Zip _____

Phone #: Home _____ Work _____ Cell _____

Email _____

Other _____

Would you like a text appointment reminder? __ No __ Yes Number to text _____

Payer (if not client) name _____ SS# _____ DOB____

Address _____ City _____ State ____ Zip _____

Phone #: Home _____ Work _____ Cell _____

Emergency contact _____ Relationship to client _____

Address _____ City _____ State ____ Zip _____

Phone #: Home _____ Work _____ Cell _____

Primary insured _____ SS# _____ DOB _____

Insurance ID# _____ Group#_____

Insurance plan_____

Employer _____ Insurance member services phone # _____

Referred by: _____

Carolyn Flynn, MC, LPC
480-395-1427
Client_____ Date_____

CONFIDENTIAL CLIENT INFORMATION

REASON FOR VISIT _____

_____

_____

_____

_____

_____

_____

_____

AREAS OF CONCERN

__ Abuse __ Acting Out __ Addictive Behavior __ Alcohol __ Anger__ Anxiety __ Body Image __ Boundaries __ Bereavement
__ Career __ Children __ Chaos __ Chronic Illness __ Communication __ Compulsions __ Confidence __ Dating __ Death
__ Depression __ Disruptive __ Divorce __ Drugs __ Eating Disorder __ Family __ Fear __Financial __ Focus __ Food
__ Friendships __ Grief __ Hallucinations __ Health __ Homicidal __ Hopelessness __ Hyperactive __ Impulse Control __ Infidelity
__ Irritable __ Isolation __ Legal __ Lifestyle __ Loneliness __ Loss __ Medical __Mental Illness __ Mood Swings __Marital
__ Meaninglessness __ Neglect __ Obsessions __ Out Of Control __ Pain __ Panic Attacks __ Parents __ Parenting __ Psychosis
__ Relationships __ Religion __ Resources __ School __ Self-Confidence __ Self-Esteem __ Sexual __ Sleep __ Social __ Spiritual
__ Stress __ Substance Abuse __ Suicidal __ Support __ Task Completion __ Time Management __ Trust __ Unhappy __ Violence
__ Weight __ Work

_____

_____

_____

GOALS FOR THERAPY

__ Build trust __ Feel happy __ Feel peace __ Increase self-confidence __ Increase self-esteem __ Identify resources
__ Improve academic/work function __Improve communication __ Improve/eliminate symptoms __ Improve relationships
__ Improve time management __ Manage anger __ Manage stress__ Reduce/cease substance use __ Stabilize mood

_____

_____

_____

DESIRED RESULTS OF THERAPY (How you will know you've achieved your goals)

1. _____
2. _____
3. _____
4. _____

Client Signature _____ Date _____

Carolyn Flynn, MC, LPC
480-395-1427
Client_____ Date_____

MEDICAL RECORDS INFORMATION

Adult Medical Record: The medical record is kept for the individual seeking treatment. At any time you may invite guests (family or friends) to join you in counseling for support or to work on relationship issues. Your guests do not have any rights to the medical record even if they attend all sessions with you.

PROTECTED HEALTH INFORMATION (HIPPA)

The law protects the confidentiality of your medical record and treatment. To protect your privacy rights I am unable to converse with any outside party about your treatment, appointment scheduling, or acknowledgement that you are receiving counseling without your authorization. This includes spouses (except for couples joint medical record), parents of adult children, church clergy, and anyone else other than the parents/guardians of a minor receiving counseling.

Any third party payers you authorize for payment of services are granted limited authorization to your personal information to complete payment of services.

At this time you can choose to list individuals you would like me to be able to communicate with for purposes of continuity of care by phone or email in regards to your treatment scheduling, status, or progress by adding their information to the Limited Release of Information form found on the next page. You may add or remove anyone from this list at anytime during your treatment. Authorization to release information is always optional and up to your discretion, and may be revoked at any time.

Your records and personal information are protected by law and will never be shared with any entity unless authorized by you. All records will be appropriately stored and destroyed in accordance with Arizona's guidelines for medical records.

I understand my rights of protected health information.

Client signature _____ Date _____

Carolyn Flynn, MC, LPC
480-395-1427
Client_____ Date_____

LIMITED RELEASE OF INFORMATION

I authorize Carolyn Flynn, MC, LPC, to communicate with the individuals listed below as needed for the purpose of continuity of care; by phone or email in regards to my treatment scheduling, status, and progress. I understand any request for written treatment records, summaries, treatment plans, etc. will require a separate release form.

Date _____

Client _____ Signature _____

_____

Primary Care Physician _____

Address_____ City _____ State ____ Zip _____

Phone number _____ FAX # _____

_____

Psychiatrist or Psychiatric Nurse Practitioner_____

Address_____ City _____ State ____ Zip _____

Phone number _____ FAX # _____

_____

Name & title_____ relationship to client _____

Address_____ City _____ State ____ Zip _____

Phone numbers/fax/email _____

_____

Name & title_____ relationship to client _____

Address_____ City _____ State ____ Zip _____

Phone numbers/fax/email _____

_____

Carolyn Flynn, MC, LPC
480-395-1427
Client_____ Date_____

LIMITS OF CONFIDENTIALITY

As a therapist I am required to disclose confidential information if any of the following conditions exist:

- Any reported or suspected neglect or abuse to children, elderly, or others who may not be able to defend or speak up for themselves. For minors: any current or past childhood abuse that has not previously been reported to CPS.

- Any threat to harm oneself or another person(s).

- Release of information to other professionals or individuals as authorized by the client or parent/guardian. Release of clinical information to an insurance provider, treatment facility, or other professionals for pre-authorization of requested services and treatment. Release of clinical information to other professionals for the purpose of treatment consultation or continuity of care (includes emergency covering provider, billing services, or collections agency if used).

- The client dies and communication regarding the client's state of mental health is important to decide an issue concerning a deed, conveyance, will or other writing executed by that client.

- Court cases: when subpoena by the court; when the client wishes to use their therapy to support a court case (i.e. custody suit or suit for mental/emotional damages); the client files suit against their therapist for breach of duty or the therapist files suit against their client.

- MINORS: Parents have the right to be informed of any activities or behaviors that may be deemed as dangerous or age inappropriate, including, but not limited to, drug and alcohol use, sexual activity, gang membership, and threats to harm self or others.

- COUPLES, FAMILY, OR GROUP THERAPY: the therapist cannot guarantee that the members of any group will uphold confidentiality, though all group members are requested and encouraged to maintain confidentiality.

I have read and understand the limits of confidentiality as stated above.

Client signature _____ Date _____

Carolyn Flynn, MC, LPC
480-395-1427
Client_____ Date_____

TREATMENT CONTRACT

I understand that counseling is a team effort and requires my commitment, trust, and willingness to experiment with new ideas and behaviors to achieve my desired goals.

I understand that as a client, I am responsible for identifying concerns and problem areas, discussing potential solutions, setting goals, and completing agreed upon homework exercises.

I understand that regular attendance will produce the maximum possible benefits. I also understand and accept that because of factors beyond our control the benefits and desired outcomes cannot be guaranteed.

I understand that I am free to discontinue treatment at any time for any reason, and will notify my therapist if I wish to discontinue services. I also understand that my therapist may refer me to another provider or treatment program if needed for continuity of care.

I understand that I am financially responsible for my treatment and agree to pay the current billing rate at the beginning of each session or prior to my appointment. I understand that I will receive a receipt for services paid. I understand that if I want to use my insurance out-of-network benefits or be reimbursed by my church it is up to me to submit the receipt and follow-up with any reimbursement.

I understand that I am expected to attend scheduled appointments on time, and will not receive additional time or financial discount if I am late. If I must cancel an appointment I agree to give 24-hour prior notification by phone or text at 480-395-1427. I understand I will receive a confirmation text or phone call once the therapist has received my message. I understand that it is up to me to make sure my therapist is notified in a timely manner. If I fail to give 24-hour prior notification, or miss a session, I agree to pay a $75 fee.

I understand that counseling appointments may be made for in-office, or by phone or Skype. I understand I may change my in-office visit to a phone appointment if needed for convenience, or emergencies that may arise in scheduling including, but not limited to, transportation problems, work conflicts, illness, babysitter cancellations, and any other unforeseen events that may prohibit me coming to the office. I understand that my therapist will do her best to accommodate my emergency, but cannot guarantee a same-day appointment change. I agree to pay the $75 fee if I am unable to make my appointment.

I agree to pay an additional $25 service fee for any returned checks. I agree to pay for repairs to any damage myself or my child incurs on office property. I understand delinquent accounts will go to collections and be reported on my credit report.

I understand voicemail and text messaging at 480-395-1427 is available for my use at all times for any reason.

I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats of harm to myself or another person.

I have read and understand the above statements, and I agree to participate fully and voluntarily as a client in psychological treatment services. I authorize Carolyn Flynn, MC, LPC, to provide psychological treatment services to myself, or my child.

Client signature _____ Date _____

Carolyn Flynn, MC, LPC

CLIENT COPY

Carolyn Flynn, MC, LPC

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