Andrea Cairella, MC, LPC
Andrea@TruePotentialCounseling.com * www.TruePotentialCounseling.com

Many clients have indicated that they are able to get the most out of counseling when they are clear about their part and my part in the process. Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort and commitment on both our parts and may at times result in experiencing discomfort.

My responsibilities in the process include:

- Listening and understanding you and your concerns.
- Helping you identify attainable treatment goals.
- Utilizing all my abilities and skills to assist you in reaching your goals by accessing your strengths and innate resources.
- Offering support as you travel your healing journey.

Your responsibilities include:

- Being as open and honest as possible.
- Setting realistic goals.
- Working to achieve your goals through commitment to attending regular therapy and completing assignments.
- Being willing to be curious and learn about the amazing being you are.

Mutually, we will need to be considerate of each other's time and resources and keep our scheduled appointments. Since an appointment reserves time specifically for you, a minimum of 24-hour notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for sessions missed without notification. Most insurance companies do not reimburse for missed sessions. To allow for sufficient time for in-depth work, I offer a 60-minute session, which is charged at a rate of $150.00 per session. If you would like additional time, I charge $25.00 for each subsequent increment of 15 minutes. Payment is expected at the time of the service. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I will give you a receipt at each session. Upon request, I could also provide you with a monthly billing summary if required for you to submit to your insurance company.

Maintaining your confidentiality is very important to me. What you say to me and the written records pertaining to our sessions are confidential and may not be revealed to anyone without your written permission, except when disclosure is required by law. I am required to disclose and report where there is a reasonable suspicion of child, dependent or elder abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled. Maintaining your safety and the safety of those in your life is also very important to me. Additionally, disclosure may be required pursuant to a legal proceeding by or against you. You will be notified immediately if any of these situations should arise.

In circumstances where a minor is being treated their confidentiality too will be honored; however, both parents are entitled to their child's progress of their child and if there are concerns

about the minors safety parents this information will be disclosed. Prior to this disclosure the minor will be informed beforehand. In cases where there are unique custodial issues relevant to your minor, please provide a copy of the current legal custody ruling.

I am committed to providing you with the best possible counseling. I believe that counseling cannot only be very helpful, but can also be fun and interesting. In my quest to acquire sound clinical skills to assist you, I have been trained in several modalities of therapy, including but not limited to, Dialectical Behavioral Therapy skills (DBT), Emotionally Focused Couple's Therapy (EFT), Eye Movement Desensitization and Reprocessing (EMDR), Gestalt Therapy and Clinical Hypnosis. These techniques have been proven to be very effective. Not all clients and client issues are appropriate for all types of therapy and we will determine together which will be most helpful for you. You will be given significant amounts of information and psycho-education to help you with this process. I do not provide custody evaluation recommendation, nor medication or prescription recommendation nor legal advice, as these activities do not fall within the scope of my practice or expertise.

It is important that you understand that therapy brings about awareness and change and that may initially cause some additional discomfort and distress. It is not uncommon for clients to continue to process distressing material between sessions. We will be monitoring your level of distress throughout this process and I encourage open disclosure of how this process "feels" to you. I will want to provide you with additional skills and support as needed. During times of extra distress, I will make myself reasonably available for crisis calls at the above number. If, however, you are not able to reach me and need immediate support or I am not able to get back to you within an acceptable time, please call the **Empact Crisis Line at (480)784-1500**. Change will sometimes be easy and swift, but more often it will be slow and even frustrating.

We will work together to formulate a treatment plan after the first couple of sessions. If I assess that I cannot be of benefit to you, you will be given a number of referrals who might be more suited to your particular needs. If at any point during therapy I assess that I am not effective in helping you reach your therapeutic goals, I am obligated to discuss it with you and, if appropriate, terminate treatment. In such a case, you will be given a number of referrals to continue your healing. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

Please be open and let me know what aspects of counseling seem to be the most and least useful for you. I consider it a privilege to walk the healing path with a fellow sojourner and am looking forward to walking with you!

I have read the above Agreement, Informed Consent, Office Policies and General Information carefully (total 2 pages). I understand them and agree to comply with them:

____

Client name (print) Date Signature

____

Client name (print) Date Signature

____

Psychotherapist Date Signature

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CLIENT BIOGRAPHICAL INFORMATION

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Informed Consent/Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: ____

DATE OF BIRTH/PLACE: ______________________________ **AGE:** _______

ADDRESS: ____

TELEPHONE: H: ________________ **Cell:** ________________ **W/Off:** ________________

EMAIL ADDRESS: ______________________________________

Is it ok for me to leave you messages on any or all of these phones: Yes No (please specify)

HIGHEST GRADE/DEGREE: ________________ **TYPE OF DEGREE:** ________________

PERSON & PHONE NO. TO CALL IN EMERGENCY: ______________________________

REFERRAL SOURCE: ______________________________________

OCCUPATION (former. if retired): ______________________________

Reflecting on the last 6 months, Check all that apply

Frequently sad or depressed		Don’t like vacations	
Frequently anxious		Financial difficulties/ excessive debt	
Mood swings		Excessive anger or rage	
Easily upset or angered		Excessive conflict	
Withdrawn or isolative		Repeat certain behaviors over and over again	
Strong fears		Increasingly forgetful	
Cry easily/often		Difficulty finishing tasks	
Change in sleep pattern		Insomnia	
Change in appetite		Nightmares	
No interest in hobbies		Difficulty with work or school	
Feeling hopeless		Excessive sweating	
Shy with people		Headaches/migraines	
Difficulty making a decision		Dizziness	
Fatigue		Fainting spells	
Trouble concentrating		Stomach aches	
Feeling lonely		Vomiting	
Feeling different from most people/ inferior		Feeling ill/ sick	
Change in sexual behavior/libido		Thoughts of hurting others	
Difficulty concentrating		Threats to hurt self	
Difficulty motivating		Thoughts of hurting others	
Too neat and orderly		Threats to hurt others	
Overwhelming worries		Use of Sedatives	
Unable to relax		Use of pain killers and analgesics	
Don’t like weekends		Other:	

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you…):

____

____

Estimate the severity of above problem: Mild   Moderate   Severe   Very severe

CURRENT: Marital status:______Live with someone:____ Name: ________________________Years: ______

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

____

____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1.____

2.____

3.____

4.____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:____

____

Mother:____

____

Step-parents____

____

SIBLINGS (name/age (if dead: age and cause of death) & brief statement about the relationship):

1.____

2.____

3.____

MEDICAL DOCTOR/S (name /phone): ____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

____

____

SPECIFY MEDICATIONS you are presently taking and for what.

____

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments)**:**

____

____

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)

____

____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc)**:**

____

____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

____

____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1. ____

2. ____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

____

____

____

IF PARENTS DIVORCED: Your age at the time: ______, Describe how it affected you at the time

____

____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

____

____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

____

What gives you the most joy or pleasure in your life?

____

____

What are your main worries and fears?

____

____

What are your most important hopes or dreams?

____

____

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NOTICE OF PRIVACY PRACTICES

I. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY**

II. **LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).** I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice. PHI I is "disclosed" when it is released transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this notice. However, I reserve the right to change the terms of this Notice and my privacy policies at anytime. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me or you can view a copy of it in my office.

III. **HOW I MAY USE AND DISCLOSE YOUR PHI** I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of, my uses and disclosures along with some examples of each category.

a. **Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

   i. ***For treatment***. I can disclose your PHI to physicians, psychiatrists, psychologist and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist. I can disclose your PHI to your psychiatrist in order to coordinate your care.
   ii. ***To obtain payment for treatment***. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
   iii. ***For health care operations***. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.
   iv. ***Other disclosures***. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

b. **Certain uses and Disclosures Do Not Require Your Consent**. I can use and disclose your PHI without your consent or authorization for the following reasons:

   i. ***When disclosure is required by federal state or local law, judicial or administrative proceedings or law enforcement.*** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
   ii. ***For public health activities***. For example, I may have to report information about you to the county coroner.
   iii. ***For health oversight activities***. For example, I may have to report information to assist the government when it conducts an investigation or inspection of a health provider or organization.
   iv. ***For research purposes***. In certain circumstances I may provide PHI in order to conduct medical research.
   v. ***To avoid harm***. In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
   vi. ***For specific government functions***. I may disclose PHI to military personnel and veterans in certain situations. And I may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations.

vii. ***For workers' compensation purpose***. I may provide PHI in order to comply with workers' compensation laws.

viii. ***Appointment reminders and health related benefits or services.*** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

c. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

i. ***Disclosures to family, friends, or others***. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

d. **Other Uses and Disclosures Require Your Prior Written Authorization**. In any other situation not described in sections III A, B and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. **WHAT RIGHTS YOU HAVE REGARDING YOUR PHI** you have the following rights with respect to your PHI.

a. ***The Right to Request Limits on Uses and Disclosures of your PHI***. You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am " legally" required or allowed to make.

b. ***The Right to Choose How I Send PHI to You***. You have the right to ask that I send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

c. ***The Right to See and Get Copies of Your PHI.*** In most cases you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI I collected in connection with a legal proceeding. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more that $.45 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

d. **The *Right to Get a List of the Disclosures I have Made***. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those named for treatment, payment, or health care operations directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or disclosures made before April 15, 2004.

e. ***The Right to Correct or Update Your PHI.*** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) Correct and complete, (b) not created by me, (c) not allowed to be disclosed, and/or (d) not a part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI , tell you that I have done it and tell others that need to know about the change to your PHI.

V. **HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES**. If you think that I may have violated your privacy rights, or you disagree with a decision I made about your access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S. W. Washington, D.C. 20201. I will take no retaliatory action against you if you make a complaint about my privacy practices.

VI. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAINT ABOUT MY PRIVACY PRACTICES.** If you have any questions about this notice or any complaints about my privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services please contact your individual provider.

VII. **EFFECTIVE DATE OF THIS NOTICE**. This notice went into effect on April 14, 2004

Andrea Cairella, MC, LPC
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed and received a copy of the *Notice of Privacy Practices* for True Potential Counseling, the counseling practice of Andrea Cairella, MC, LPC:

Print name: ____

Signature: ____

Date:
____