C L I E N T I N F O R M A T I O N

Today's Date:

Referred By:

Client Name:

Date of Birth:

Social Security Number:

Mailing Address:

Health Insurance ID Number:

City, State, Zip:

Phone (home):

Phone (work):

Employer:

Party Responsible for Payments (or the person insured)
Name:

Date of Birth:

Health Insurance ID Number:

Mailing Address:

Phone (home):

Phone (work):

City, State, Zip:

Employer:

Insurance Company Name:

Phone:

Billing Address:

Group Policy Number:

City, State, Zip:

Deductible: per: begins:

Specific Requirements:

Number of Sessions:

Services Not Allowed:

CARLTON F. "PERK" CLARK, LCSW
PSYCHOTHERAPY & ORGANIZATIONAL DEVELOPMENT, LLC
350 S WILLIAMS BLVD SUITE 140 TUCSON AZ 85711-7416
TEL: 520/519-8475 FAX:520/519-8476 EMAIL: perk@psychod.com WEB: www.psychod.com

F E E S A N D C A N C E L L A T I O N S

Fees:

My sliding fee is $120 - $160 for a fifty-minute session of psychotherapy. Please have your check made out when you arrive for your session, or pay online before you arrive. If you are unable to pay this fee, please ask me about referrals to other therapists for you.

This hourly fee is charged for all interviewing, therapy meetings, planning, reports, making notes, writing letters, telephone conversations and copying records.

Included in the fee is my online billing of insurance companies for your services, submitted bimonthly. Insurance reimbursements vary dramatically in accord with decisions by your employer and you to purchase coverage with and without psychotherapy benefits.

You are ultimately responsible for the fees charged here for your services even if your insurance company decides later to not reimburse you. If you choose to not pay your fees, I will refer them to a collection agency and will add the agency's collection fee as well. All returned checks incur a charge of $25.00 for bookkeeping expenses.

Cancellations or Missed Meetings:

If we agree to work together we are creating a contract to meet a certain number of times per week at a specific charge per meeting. If you decide that you are not available for a contracted meeting, I will offer to reschedule that meeting during that same calendar week if I have an available hour in my standard weekly schedule. If your meeting date falls on a holiday I will ask you to reschedule for another day in that same week.

You will be billed for any contracted hour of service that you decide to not attend (much like in educational settings where you pay a fee for a course but chose to not attend certain meetings). You will not be charged for scheduled meetings when you are out of town or ill during an entire week. I do not offer to cancel meetings at no charge.

If your insurance company is a managed-care firm you will also be charged for their full fee for the missed meeting, not just the co-payment you ordinarily pay.

"I have read the above agreement and wish to continue with the evaluation and the treatment. I agree to the cancellation policies and to pay the fee specified above at the time of each appointment unless special arrangements have been made."

_____

Client Name (Please Print) Client Signature

_____

Responsible Party Name (Please Print) Signature of Responsible Party

Date _____

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S Y M P T O M C H E C K L I S T

ALL OF YOUR ANSWERS to these questions are strictly confidential, protected by State and Federal laws. No one (friend, parent, partner, employer, insurance company) has access to this information without YOUR written permission.

Name: _____

Date: _____

Please place a number (from 0 to 3) in the gray boxes below that describes the severity of any experience you are having that concerns you or someone close to you.

Here are what the numbers mean:

0 = no problem
1 = mild problem
2 = moderate problem
3 = severe problem

SYMPTOMS AND PROBLEMS	SEVERITY RATING
Anxiety	
Anger Problems	
Appetite Disturbance	
Bizarre Behavior	
Bizarre Ideas	
Conduct Problems	
Depression	
Food Cravings	
Gender Issues	
Impaired Memory	
Independent Living Problems	
Obsessive Compulsive	
Panic Attacks	

SYMPTOMS AND PROBLEMS	SEVERITY RATING
Paranoid Ideas	
Phobia	
Poor Interpersonal Skills	
Poor Judgment	
Poor Self-Care Skills	
Relationship Problems	
Sexual Dysfunction	
Sleep Disturbance	
Somatization (weird body problems)	
Substance Abuse	
Suicidal Thoughts	
Thoughts Intrude	
Other:	
Other:	

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Please Read!!

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Tucson, AZ 85711-7416
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Some Information About My Psychotherapy Practice

Training and Experience:

In practice since 1975, I studied at Arizona State University School of Social Work and was employed in state and federally funded behavioral health programs with adults and adolescents. I trained privately in gestalt therapy, bioenergetic analysis, ego psychology, methods of family and group psychotherapy, short-term psychotherapy, and transpersonal psychology. I have national and state certification as an independent social worker, and received a masters degree in 1984. In 2000 I was an Adjunct Lecturer at the University of Arizona Psychology Department on the topic of transpersonal psychology.

Fee and Payment Schedule:

The fee for my services is $120-160 per meeting for individual, couple, or marital meetings, and $55 per group meeting. Please have your check made out when you arrive, and pay that fee at the time you are offered the service. Remember that you are liable for the full charges no matter what portion your insurance company decides they will pay.

Frequency of Meetings:

We will agree on a frequency of our meetings, depending on the degree to which you are willing to pursue the issues that brought you here. Clients usually attend a minimum of once a week to promote continuity and to keep us both focused on what you are hoping to achieve and what is in the way. Meetings begin on the hour and last for 50 minutes. If at some point you decide to change the frequency of your meetings, please bring this up at the beginning of any session for discussion.

Cancellations and No Shows for Meetings:

If we agree to work together we are creating a contract to meet for a certain number of times per week at a specific charge per meeting. If you decide FOR ANY REASON that you are not available for a meeting you have contracted for please notify me. You will still be billed for that hour (much like in educational institutions where you pay for a course even though you chose to not attend all the meetings). If I have another time available during that same week on my regular schedule of hours I will offer it to you at no additional charge.

Emergencies:

I do have a 24 hour answering service but do not carry a beeper. My office hours are Monday & Wednesday (8am - 4pm), Tuesday & Thursday (8am - 3pm). If my service cannot locate me, they will refer you to Help-on-Call, a 24 hour crisis center (323-9373).

(See Page Two)

Clinical Supervisor:

My consulting supervising psychiatrist is Arnold Nelson, MD, and I present cases in a confidential small-group every other week. At some point I may be presenting your case (minus your last name) to this supervising team. Tell me if this is a problem.

Vacations, Holidays, Training Events:

When these events in my practice conflict with our regular meeting days, I will ask to reschedule our meeting to fit within that same week.

Confidentiality:

State and federal laws support your right to have a confidential relationship here, and no information about your presence will be released to any party (except my supervision group) without your written permission. There are two laws which disrupt this: (1) in case of child abuse, reported to me by the child him or herself, I must notify Child Protective Services; and (2) in case you report a clear intent to harm others, I must notify the police.

Interpersonal Types Testing:

Written tests to identify elements of your relationship style with others are also available at a fee of $125 for one such test and its interpretation.

Progress:

You have the right to know what diagnosis you have been given, and your treatment plan here. It is important that you keep me informed about your observations of progress, or the lack of it, in this work. Remember that while I am responsible for the professional conduct of this therapy hour, you yourself are in charge of what issues you present, and how you will pursue them in the course of you life.

Payments and Health Insurance:

Each health insurance policy has unique standards about eligible service providers, the number of visits they will support, deductible costs, and appropriate fees for services. I will submit insurance forms for you, but you must be responsible to pay in full for your services and work out with the company various rulings that they make regarding payments.

Referring Others Here:

My most consistent sources of referral are current or former clients who often send friends or relatives. This is of course appreciated, but it can on occasion pose a difficult problem if your issues and theirs overlap. Please mention this to me if you do intend to make such a referral.

Public Speaking and Training:

I do speak on topics about individual, couple, and organization functioning which might be relevant to your workplace, church, or service club. Please inquire if interested.

October 2010

Carlton F. Clark / Psychotherapy & Organizational Development

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *National Association of Social Workers Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. Please note also that mail sent to you from this facility will include our return mailing address.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about

you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 350 S Williams Blvd Ste 140 Tucson AZ 85711.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Carlton F Clark 350 S Williams Blvd Ste 140 Tucson AZ 85711 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is April 14, 2003.

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Carlton F. Clark/Psychotherapy & Organizational Development's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Carlton F. Clark at (520) 519-8475.

_____

Signature of Client **Date**

_____

Signature or Parent, Guardian or Personal Representative **Date**

_____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

CARLTON F. "PERK" CLARK, LCSW 10/19/10
PSYCHOTHERAPY & ORGANIZATIONAL DEVELOPMENT, LLC
350 S WILLIAMS BLVD SUITE 140 TUCSON AZ 85711-7416
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Informed Consent for Treatment

The purpose of this treatment is for you to present concerns and symptoms that you or a significant other may have about you regarding your functioning in your relationships and your workplace. Psychological, emotional, behavioral, marital, spiritual –religious matters are the kinds of topics that are addressed here.

The goal of the treatment is that by presenting your concerns you will achieve insights into them, become more consistently aware of and learn new ways of addressing them, and practice those new ways more frequently. Thus you yourself will diminish your own symptoms and suffering while strengthening various skills and traits that serve you and your surrounding world.

The general procedures to be used in this treatment are those of counseling and psychotherapy: an assessment of your concerns, a diagnosis regarding them, a treatment plan, and then the repeated discussion regarding your concerns. Specifically you will be encouraged to become more and more aware of your emotions, thoughts, motivations, behaviors, dreams, and beliefs. Within these you will begin to identify elements that are likely preventing you from addressing your suffering in a more effective way.

The benefits, limitations, and potential risks of this treatment:

- Benefits: Psychotherapy has the potential to result in increased client functioning in love and in work. Your relationships with significant others can become more successful and less stressful. You can learn to manage your own emotions, respond in new ways, adapt to changing circumstances with equanimity. To become more aware of your behaviors, emotions, thinking, and perceptions is to discover which are conditioned, automated, and ineffective. This sets the stage for you to practice interrupting those responses that are self-limiting.

- Limitations: No guarantees can be made about the benefits of this treatment whatsoever. Treatment results vary significantly from client to client as a factor of many elements:
    - ❖ the fit with the psychotherapist, in which you can work effectively with him or her, much as teammates do in any setting
    - ❖ the specific kind of suffering that has brought you here
    - ❖ the intensity and duration of the suffering you are enduring
    - ❖ your previous efforts and experiences of addressing this
    - ❖ the degree to which you can work actively outside of therapy on your treatment plan to struggle with the matters that concern you
    - ❖ the length of time you attend, and the frequency of attendance

  While many thousands of studies have concluded that there is a high probability that psychotherapy is effective, none have concluded that positive outcomes will occur on every incident of treatment.

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- The Potential Risks: Possible risks of this treatment include…
    - the identification of troubling aspects about yourself
    - the experiencing of strong states of emotion, positive & negative
    - the disappointment of other family members if your role with them changes in some fashion
    - states of confusion regarding your work here
    - the inability-unwillingness on your part to carry out a treatment plan, thus decreasing your benefit from your investment

You have the right to have your records kept confidential, which means that they are not released to anyone without your written permission.

The limits of that confidentiality are several:

- when applying for your health insurance coverage reimbursement, your name, diagnosis, dates of service are submitted
- when you apply for a national security clearance and sign over the access to these records to a national security agency
- when your case is presented (without identifying information about your name, etc.) to a group of professionals in a clinical supervision setting
- if you are a medical professional, your Licensing Board can access your records here without your permission if a complaint has been filed against you
- when a child indicates that they have had sexual contact with you
- when you indicate a clear intent to harm someone

In all the above cases your confidentiality is not assured. In the last two situations cited, the law states that I must notify the authorities . I will in all cases notify you that any request for your information has been received. If you wish to seek information about your client records here, please send me written notice.

You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You have the right to refuse any recommended treatment or to withdraw informed consent to treatment and to be advised of the consequences of such refusal or withdrawal.

You have the right to be informed of all fees that you are required to pay and my refund and collection policies and procedures. Please read and sign the attached “Fees and Cancellations” document.

There are limitations about providing this treatment via electronic media, especially since telephones, email, and Internet do not allow for the transmission of a great deal of information about your current state. For instance, your actual identification, posture, emotion, affect, eye contact, and disposition are much

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harder to ascertain when you are separated from the therapist via an electronic connection. Communication via electronic media does not take the place of face-to-face psychotherapy, and it is not confidentially secure.

I am obligated to obtain from you a signed informed consent for treatment before audio taping, video taping, or permitting a third party to observe any treatment that I provide to you.

I meet regularly with a group of licensed behavioral health professionals (psychiatrist; social workers) in clinical supervision and may at some point be presenting your case. By signing the attached signature page you are giving me the authority to present your case, minus any identifying information (your last name, workplace, or that which would alert those others to your identity). If you wish to not grant that authority, I will ask for that in writing too and will honor it.

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Informed Consent for Treatment

Signature Form

Patient/Client Name:_____

Date of Birth: _____

Social Security Number:_____

I hereby acknowledge that I have received and have been given an opportunity to read the two pages of Carlton F. Clark/Psychotherapy & Organizational Development's Informed Consent for Treatment form. I understand that if I have any questions regarding the consent or my rights, I can contact Carlton F. Clark at (520) 519-8475.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative* Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member Date

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R E L E A S E O F I N F O R M A T I O N

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ _____
Print Name **Date of Birth**

authorize: _____Carlton F. "Perk" Clark _____

to disclose to: _____

the following information: _____

_____

for the purpose of: _____

I understand that my records will not be disclosed without my written consent, unless otherwise provided for in the regulations that govern social workers. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as described below. **I hereby specify the date, event, or condition upon which this consent expires:**

_____

Executed this _____ **day of** _____ **, 20** ____ .
date month year

_____ _____
Signature of Client **Signature of Witness**

_____
Parent/Authorized Person

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