Nicole Sbordone
LCSW

Client Information

(Please complete and sign all forms, and bring all pages to your first session.)

Name: _____
Last First Middle Initial

Date of Birth:_____/_____/_____
Month Day Year

Street:_____**Unit:** _____

City:_____**State:**_____**Zip:** _____

	Confidential Voicemail?		Message Can Be Left With Another Person?	
Home Phone:_____	Y	N	Y	N
Cell Phone:_____	Y	N	Y	N
Work Phone:_____	Y	N	Y	N

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Alt. Emergency Contact Name: _____

Alt. Emergency Contact Phone: _____

How did you hear of this counseling practice? (Check One)

___PsychologyToday.com
___Other online search
___Family member or friend
___Physician or other Healthcare Professional
___Other _____

Client Rights

Any person who receives services for mental health, alcoholism, drug abuse or developmental disability is guaranteed certain rights. Among these rights are the following:

1. You must be treated with dignity and respect, free of any form of abuse.
2. You have the right to have your therapist make fair and reasonable decisions about your treatment.
3. You cannot be treated unfairly because of your race, national origin, sex, religion, age, disability or sexual orientation.
4. You must be provided prompt and adequate treatment and other services which are appropriate to your individual needs.
5. You must be allowed to participate in the planning of your treatment.
6. You have the right to discuss positive and negative effects of your treatment and to discuss alternative treatments with your therapist.
7. No treatment may be given without your consent except in an emergency.
8. You have the right to know the cost of your treatment and to discuss these costs with your therapist.
9. You will not be filmed or taped without your written permission.
10. Information regarding your treatment must be kept confidential unless you have released them.
11. Your records cannot be released without your signed authorization, except in other instances as outlined by HIPAA. (See HIPAA Notice of Privacy Practices.)
12. You have the right to see your records and to discuss them with your therapist.
13. You may challenge the accuracy of your records and have corrections placed into the record.
14. If you feel your rights have been violated, you may file a grievance. The grievance policy is outlined under the policies section.

I have read and understand these rights.

_____ _____

Client Signature Date

Receipt of Notice of Privacy Practices

I have read, understand, and have been provided a copy (via website or hard copy) of Nicole Sbordone, LCSW (NHZ, PLLC) privacy policies regarding the protection of my health information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Client Signature Date

Authorization for Contact by Telephone/Verbally in Event of Breach of PHI

I authorize Nicole Sbordone, LCSW (NHZ, PLLC) to provide notice to me by telephone or verbally in the event of a breach of my Protected Health Information (PHI) by Nicole Sbordone, LCSW (NHZ, PLLC).

Such conversation shall be documented by Nicole Sbordone, LCSW (NHZ, PLLC).

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me, pursuant to this authorization, shall not be simply for the administrative convenience of Nicole Sbordone, LCSW (NHZ, PLLC).

_____ _____

Client Signature Date

Informed Consent To Treatment

Psychotherapy is a process designed to help people learn to function better and feel better in their daily lives. People seek therapy to change emotional, interpersonal or behavioral issues. In many instances people who do not receive treatment for emotional problems report that their distress increases and this can lead to a significant disruption in mental, interpersonal and physical functioning. Initially, many people report feeling an increase in distress as they come to grips with important issues. Through therapy, people oftentimes make changes in personal coping strategies, careers or relationships. These changes can be distressing to the individual, to family members and to friends. It is important that you understand the risks and implications of beginning therapy, discontinuing therapy or changing your treatment plan. Your specific situation is unique and will be discussed in detail with your therapist.

I realize that my initial treatment plan should be developed with my therapist and approved by me. My treatment plan will evolve as my needs change and each change should also be discussed and approved by me. I understand that my therapist and I will review my treatment plan at least annually. I understand that my therapist and I should regularly discuss the implications of my continuing in therapy, adjusting the modality of therapy, seeking alternative treatment, and the implications of terminating therapy. I also understand that it is my right to make any of these decisions. I further understand that my therapist is responsible to provide therapy which she believes to be effective and appropriate to my needs. I am also aware that my therapist consults regularly with a consultation team of therapists and therefore may discuss my case if guidance is needed (client name and other identifying information will not be shared). I understand that any communication via cell phone or email may be heard or read by a third party, as these are not secure forms of communication. Therefore, I understand that my therapist does not communicate clinical information over email, text, or other electronic means and prefers to discuss clinical information or concerns only in-person or over the phone.

For parents/guardians of children:
I attest that I have the legal right to consent to treatment for this child. I hereby consent to begin therapy.

_____	_____	_____
Client Name (print)	Client Signature	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Signature	Date
_____	_____	
Therapist Signature	Date	

Policies of Nicole Sbordone, LCSW (NHZ, PLLC)

Billing and Payment

My billable rates are as follows:

- $165 per hour

Other session-length times are available upon request and based on clinical need, and are prorated at the above hourly rate.

Letter and report writing, consultations with other health care providers (at the request of the client), or telephone contacts with clients, lasting over 10 minutes, are charged at the same pro- rated cost, based on 10 minute increments.

Copies of records, if requested, are charged at $.50 per page plus administrative costs such as time.

Superbills

Due to being private pay (which means that I am not in-network with your plan), I can provide you with a Superbill (summary statement of charges and payments received) and you can then submit this Superbill to your insurance company for reimbursement directly to you. A Superbill contains all the necessary information to allow for processing by an insurance company.

Prior to your first session, it is encouraged that you reach out to your insurance company to obtain information regarding your out of network benefits, reimbursement rates, telehealth coverage, and deductible. Many individuals are pleasantly surprised to hear that their insurance company reimburses a significant amount for therapy sessions with out of network providers.

Clients are responsible for payment of services at the time of service.

Payment forms accepted are: Cash, personal check, HSA, FSA, or credit card (VISA, MasterCard, Discover, or American Express). If you have more than one unpaid session, I reserve the right to suspend services until your account is paid in full. In accordance with HIPAA, I have the right to release any pertinent treatment information, via paper or electronic means, to obtain payment for services.

If you do not bring payment to each session in the form of cash or check, it is a requirement that a current credit card is on file. If you overpay on your account, you either will be reimbursed by the amount that you overpaid or it will be credited to your next session. If your account is not in good financial standing, you may be referred to another provider. If you default on your payments after a 60 day time period and without payment arrangements, collection or court-related action may be taken against you. In that case, you are liable for collection or court-related costs.

I am happy to answer any questions you have about billing and payment. It is best to discuss any concerns/questions immediately so that financial matters do not interfere with your therapy.

No Shows/Late Cancellations

If no-shows or late cancellations occur (when less than a 48 hour notice is given from your appointment time), the full session fee will be charged. Because of the nature of private practice, and the amount of time we schedule for an appointment, that time is viewed as a contract between you and I. When late cancellations or no-shows occur, that time cannot be given to another client who may be in need of services. Please do not cancel appointments via email as your email may not be read in time if I am in session. If you cancel and/or no-show for two consecutive appointments and/or if you haven't been seen for 30 days without a future appointment scheduled, you may be considered an inactive client and may be discharged. If you are seeking reimbursement from your insurance company, please know that insurance companies do not reimburse for missed appointment charges.

If you are running late, please contact me right away to let me know. If I have not heard from you within the first 20 minutes of your session, I will assume that you are a "no show," your session will be forfeited, and you will be billed at your full rate (even if there is time remaining in your session).

At least two days before your appointment, I will send a confirmation text. Please always confirm your appointment. If you do not confirm, I will assume you're canceling and will cancel your appointment. If you need to cancel, please do so before the 48 hours.

Confidentiality

All of our sessions are strictly confidential. My professional code of ethics prevents me from discussing what is said during sessions with anyone other than therapy participants, or from releasing any records without the written permission of my client(s). The only exceptions to this are if someone is in danger of being harmed (i.e. abuse or neglect of a child, elder or other vulnerable adult), or if the law explicitly states that confidentiality provisions do not apply in a particular case. In addition, if you are a danger to yourself (discussing active suicidal ideation) or you discuss harming someone else, I have to break confidentiality. I may, in certain cases, consult with a colleague if I feel that I may need guidance or another opinion; in such cases, the names or identifying information of clients will not be shared. If therapy involves the participation of a partner or spouse, I do not guarantee confidentiality among therapy participants. In these cases, I will, however, use my professional discretion in deciding whether to disclose communications relayed to me. I do not connect with clients via social media (i.e. LinkedIn, Facebook, etc.) in order to protect client confidentiality. If I see clients in public, I do not initiate contact or conversation with them in order to maintain confidentiality. In those situations, it is up to clients if they wish to acknowledge or greet me, but regardless, neither the nature or details of the therapeutic relationship will be discussed by me.

Litigation Limitation

It is agreed that neither the client nor his/her attorney shall call upon me to testify in any legal proceeding (such as child custody disputes, divorce proceedings, etc.). The client expresses understanding that I do not specialize in custody evaluations or other forms of legal testimony. If you are seeking any legal testimony, I am able to provide an appropriate referral or recommendation to a specialist in this area.

Children and Adolescents

Any person under the age of 18 who is not emancipated needs parental consent for treatment. I will request parents be involved in the beginning stages of therapy to obtain their input as to the nature of the problem, etc. Periodic updates from parents are appreciated throughout therapy. However, during therapy, sensitive issues are often discussed and it is therefore recommended that therapy be viewed as confidential between the child and therapist and specific information shared during sessions be kept confidential so that the child or adolescent feels safe discussing matters, which is an indication of successful treatment. Of course, if there is a threat of harm or danger to the child, parents will be notified. It is oftentimes beneficial for other family members to join-in on some sessions, and this is done with the permission of the primary client (child or adolescent).

Emergency Services

In the case of a mental health emergency, please report to the nearest hospital emergency room, dial 911, 988 or contact the Maricopa County Crisis Hotline 1-800-631-1314 or 602-222- 9444. Please also contact me and request an emergency appointment if possible. Please note, however, that my office phone number is not an emergency number.

Referral Services

I am not a physician and therefore do not prescribe medication. If a medical evaluation is warranted, I am happy to provide you with an appropriate referral. If you require more intensive care, such as day treatment or inpatient care, a referral can be made to a facility that can accommodate your needs.

Records

Records are maintained according to state law and HIPAA. You are entitled to a copy of your records by submitting a request in writing. Please contact me with any questions pertaining to records. Because these are professional records, they can be confusing or misinterpreted; therefore, it is recommended to first request a records review with me, or have the records sent to another professional who can help you interpret them. In the event of practice closing or death of practitioner, records will be forwarded to and maintained by another licensed mental health practitioner for their duration per state law.

Grievance Policy

If you are unhappy with the services you are receiving, it is requested to talk with me so that I may respond to your concerns directly. Such concerns will be taken seriously and met with care and respect. If you believe that appropriate resolution has not been attained, you may file a formal grievance with me in writing within 45 days of the time you become aware of the problem. I will investigate your grievance and attempt to resolve it. Unless the grievance is resolved informally, I will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report. If you and I agree with the report and recommendations, the recommendations shall be put into effect within an agreed upon time frame. If you are not happy with my report and recommendations, you may request mediation with a neutral party agreed upon by you and I. The cost of such mediation will be split equally between you and I, unless otherwise agreed upon. If mediation is unsuccessful, arbitration can be settled in Maricopa County in accordance with the rules of the American Arbitration Association. You may, instead of filing a grievance, at the end of the grievance process, or any time during it, contact the Arizona Board of Behavioral Health Examiners at www.azbbhe.us, or take the matter to court if you believe your rights have been violated. No adverse action will be taken against you if you file a grievance.

I agree to the aforementioned policies (totaling 4 pages).

_____ _____

Client Signature Date

Telehealth Informed Consent

I, _____ (client), hereby consent to participate in telehealth with, Nicole Sbordone, LCSW , as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telehealth:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2. I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.

6. I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to reschedule.

7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols for Telehealth

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

Credit Card Authorization

Please Note: *It is required that all clients who do not bring payment in the form of cash or check at the time of service have a credit card on file. The credit card payment option is offered as a convenience to clients who prefer to pay by credit card and do not wish to bring cash or check to each appointment.*

I authorize Nicole Sbordone, LCSW (NHZ, PLLC) to keep my credit card on file and/or to charge my credit card for any balance due.

Credit Card Information

Client Name: _____

Cardholder Name: _____
(As it appears on card.)

Credit Card Type: ____VISA_____MasterCard_____Discover_____American Express

Account Number:_____-_____-_____- _____

CVV: _____

Expiration Date:_____/ _____
Month Year

Card Billing Address: _____
Address 1

_____
Address 2

_____ _____ _____
City State Zip

_____
Cardholder Signature Date