CounselorHeidi, LLC
Heidi L. Southern, MA
Licensed Professional Counselor
Certified Enneagram Teacher
1201 N. Colombo Avenue, Sierra Vista, AZ 85635

Welcome and thank you for considering me for your mental health needs. This document contains important information about my professional services and business policies. Please read &complete it carefully.

CLIENT INFORMATION AND CONSENT

Therapist

The undersigned therapist is a licensed professional counselor engaged in private practice providing mental health care services to clients directly.

Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur.

Appointments

Appointments are best made by messaging me at 469.955.6579. If you need to cancel or reschedule an appointment, please do so at least 24 hours in advance, or you will be charged for the missed appointment. Third-party payments (e.g. your insurance policy holder) do not cover or reimburse for missed appointments. Therefore, the charge for a missed appointment is the cash-cost of the session ($130.00).

Number of Visits

The number of sessions needed depends on many factors and will be discussed by the therapist. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. At the end of the evaluation process the undersigned therapist will be able to provide you with some first impressions of what therapy may include and a treatment plan to follow if both you and therapist agree to work together in therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with the therapist. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about procedures feel free to discuss them with the therapist at any time. If you have doubts your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

Length of Visits

Therapy sessions are 50 minutes in length.

Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. If the therapist encounters you in public setting, in order not to reveal your identity the therapist will not acknowledge your presence unless addressed by you client first. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

Cancellations

Cancellations must be received at least 24 hours before your scheduled appointment; otherwise you will be charged the full session fee ($130) for that missed appointment. _____

Payment for Services

Each 50-minute therapy session is $130.00. However, I reserve the option to make other arrangements based on individual client need. These fees are subject to change upon sixty (60) days prior notice to you. If you are unable to pay, or are not willing to pay the higher fee after receipt of notice, services will be terminated and you will be given referrals to other competent providers. The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges.

Confidentiality

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated or permitted by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in treatment facilities; sexual exploitation; AIDS/HIV and other communicable disease infection and possible transmission; court orders, criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, protect, notify or disclose; sexual exploitation by a mental health professional or member of the clergy, fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; the filing of a complaint with a licensing board or other state or federal regulatory authority; to regulatory authorities in connection with their compliance or investigatory responsibilities; to employees or agents of the practice for operational purposes, to a supervisor if the therapist is under supervision and for treatment consultations with other mental health professional when deemed necessary by the therapist. FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT. By signing this information and consent form below you acknowledge receipt of a copy of the Notice of Privacy Practices. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and consent form below, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated or permitted by law, with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist for any departure from your right of confidentiality that may result.

Risks of Therapy

Therapy is the Greek word for change. You may learn things about yourself that you don't like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

After-Hours Emergencies

Please know that your therapist does not provide twenty-four (24) hour crisis or emergency therapy services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself go to the nearest hospital emergency room for assistance.

Contacting Your Therapist

Your therapist is often not immediately available by telephone, text, or email. A reasonable effort will be made to return any call, text, or email received Monday through Thursday within 24 hours -- weekends and holidays excepted.

Email and Text Messages

The undersigned therapist uses and responds to email and text messages only to arrange or modify appointments. Please do not send texts or emails related to your treatment or therapy sessions as electronic communications are not completely secure and confidential. Any therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during

your next therapy session. You should know that any emails or texts received from you and any responses sent will become part of your therapy record.

Social Media

Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted. Any attempt by a client to surreptitiously gain access to the therapist's personal site(s) will be cause for termination of the therapy.

Therapist's Incapacity or Death

You acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form below, you give consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice. The undersigned therapist will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

Marital or Joint Therapy

If I participate in marital or joint therapy pursuant to which joint sessions are held with the undersigned therapist I consent for the undersigned therapist to maintain a single case file for all joint sessions and to release all information contained in the file maintained for joint sessions to any participant in the joint session upon request by a participant.

Video or Audio Recordings

You acknowledge and, by signing this information and consent form below, agree that neither you or the undersigned therapist will record any part of your sessions unless you and the therapist mutually agree in writing that the session may be recorded. You further acknowledge that the undersigned therapist objects to you recording any portion of your sessions without the therapist's written consent.

Defamation

By signing this information and consent form below you agree that you will not make defamatory comments about the undersigned therapist to others or to post defamatory commentary about the therapist on any website or social media site. In the event that defamatory remarks about the therapist are made by you, or others acting in concert with you, you further consent by signing this information and consent form below to allowing the therapist to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Cooperation of Client

You shall keep the undersigned therapist advised of your whereabouts at all times, and provide the undersigned therapist with any changes of address, phone number, contact information or business affiliation during the time period which the undersigned therapist's services are required. You shall comply with all reasonable requests of the undersigned therapist in connection with therapeutic treatment. The undersigned therapist may, set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including without limitation: your refusal to comply with treatment recommendations, the undersigned therapist is uncomfortable working with you or your failure to timely pay fees or deposits in accordance with this Information and Consent Form, subject to the professional responsibility requirements to which the undersigned therapist is subject. It is further understood and agreed that upon such termination of services of the undersigned therapist, any of your deposits remaining in the undersigned therapist's account shall be applied to any balance remaining owing to the undersigned therapist for fees and/or expenses and any surplus then remaining shall be refunded to you.

Duty to Warn

In the event that the undersigned therapist reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form, you specifically consent for the therapist to:

a. warn the person in danger

b. contact medical and law enforcement personnel

d. contact the following person who you consider to be in a position to prevent you from harming yourself or another person. This may be the same person as your emergency contact person:

Emergency Contact Name: _____
Emergency Contact Phone Number: _____
Emergency Contact Email Address: _____
Emergency Contact Physical Address: _____
Emergency Contact Relationship to You: _____

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your therapy with the undersigned therapist. You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that you have received and reviewed. You acknowledge that you have been advised by the undersigned therapist of the potential of the redisclosure of your protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the undersigned therapist was conditioned on you providing this authorization.

Contact Information

You consent for the undersigned therapist to communicate with you by mail, email and by phone at the addresses and phone numbers you provided in the CLIENT CONTACT section of this document, and you agree to IMMEDIATELY advise the therapist in the event of any change.

Goals, Purposes and Techniques of Therapy

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting the goals of your therapy. As therapy progresses these may change.

Therapeutic Techniques

I consider my therapeutic approach to be eclectic and I tailor my approach to the needs, concerns, and personality of each of my clients. I rely heavily on Mindfulness-Based Cognitive Therapy and Person-Centered Therapy, as well as tools such as the Enneagram, a centuries-old system of human development.

Agreement Not to Seek Testimony

Involving a treating therapist in legal proceedings can create conflicts and negatively impact therapy thereby diminishing the possibility for a successful outcome.

I acknowledge that involving HEIDI L. SOUTHERN, LPC in any legal proceedings would be disruptive to her practice and unfairly impose upon her. It is with this understanding that I hereby agree, as a condition upon which HEIDI L. SOUTHERN, LPC has consented to provide me with assessment, evaluation, and treatment, that I will not call, subpoena, or otherwise seek to compel HEIDI L. SOUTHERN, LPC, to provide oral or written testimony of any kind in any legal proceeding in which I am a party with respect to her assessment, evaluation, and treatment of me, nor will I allow any legal representative of mine to do so. I agree that any such attempts shall constitute a basis upon which a court should quash any subpoena or issue a protective order and I agree to be responsible for and to pay for any attorney fees and costs incurred by HEIDI L. SOUTHERN, LPC in attempting to secure enforcement of, and compliance with, this agreement.

In the event disclosure of your records or the therapist's testimony are required by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by the therapist at the time of the request or service of the subpoena (current rate is $200.00) for the time involved in traveling to and

from the testimony location, reviewing records and preparing to testify, waiting at the location and in giving testimony. Such payments are to be made at the time or prior to the time the services are rendered by the therapist. The therapist may require a deposit for anticipated court appearances and preparation.

Signed this _____day of _____20____.

_____

Client Signature

Consent to Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have read, understood and agreed to be bound by all the terms, conditions and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Signed this _____day of _____20____.

_____ _____

Client Signature Witnessed by Heidi L. Southern, MA, LPC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you have access to it.

Protected health information about you is obtained as a record of your contacts or visits for healthcare services. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

I am required to follow specific rules on maintaining the confidentiality of your protected health information, how your information is used, and how it is disclosed or shared with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how I will follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage health care operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. You have the right to receive and I am required to provide you with a copy of this Notice of Privacy Practices – I am required to follow the terms of this notice. I reserve the right to change the terms of this notice, at any time. If needed, new versions of this notice will be effective for all protected health information that I maintain at that time. Upon your request, I will provide you with a revised Notice of Privacy Practices.

You have the right to authorize other use and disclosure -This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or I have taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health information. You have the right to inspect and copy your protected health information - This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. In certain cases I may deny your request.

You have the right to request a restriction of your protected health information - This means you may ask me, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases I may deny your request for a restriction.
You may have the right to have me amend your protected health information - This means you may request an amendment of your protected health information for as long as I maintain this information. In certain cases, I may deny your request for an amendment.
How I May Use or Disclose Protected Health InformationFollowing are examples of use and disclosures of your protected health care information that I am permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by me.

For Treatment

I may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, I would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. I will also disclose protected health information to other physicians who may be involved in your care and treatment. I may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

For Payment

Your protected health information will be used, as needed, to obtain payment for my health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services I recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations

I may use or disclose, as needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

Other Permitted and Required Uses and Disclosures

I may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare

Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person
you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment. I may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law

I may use or disclose your protected health information to the extent that the law requires the use or disclosure. For Health Oversight I may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. In Cases of Abuse or Neglect I may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, I may disclose your protected health information if I believe that you have

been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

For Legal Proceedings

I may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Required Uses and Disclosures

Under the law, I must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

RE: Complaints

You may complain to me or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by me.

By signing this NOTICE OF PRIVACY PRACTICES, I, the undersigned client, acknowledge that I have read, understood and agreed to be bound by all the terms, conditions and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me

Signed this _____day of _____20____.

Client Signature	Witnessed by Heidi L. Southern, MA, LPC

NEW CLIENT INFORMATION

WHAT ARE THE PRIMARY GOALS YOU WISH TO ACCOMPLISH IN COUNSELING?
WHAT IS THE MAIN REASON YOU DECIDED TO SEEK COUNSELING *NOW?*
HAVE YOU SEEN A COUNSELOR IN THE PAST?
IF YES, WHAT DID YOU WORK ON?
WAS THE COUNSELING SUCCESSFUL FOR YOU?

CLIENT CONTACT INFORMATION

YOUR NAME:	**DATE OF BIRTH & AGE:**
SS#:	**PHONE:**
STREET ADDRESS:	**EMAIL:**
CITY, STATE, and ZIP CODE:	

CREDIT CARD INFORMATION

NAME ON CARD:
CARD NUMBER:
EXPIRATION DATE:
3-or-4-DIGIT SEC. CODE:
CLIENT SIGNATURE:

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED WITHIN THE PAST SIX MONTHS:

- THOUGHTS OF HURTING SELF
- THOUGHTS OF HURTING OTHERS
- ANXIETY
- DEPRESSION
- SLEEP PROBLEMS
- PANIC
- UNUSUAL THOUGHTS
- ANGER OUTBURSTS
- CHANGES IN WEIGHT
- CRYING SPELLS
- MEMORY PROBLEMS
- SEXUAL PROBLEMS
- RELATIONSHIP DIFFICULTIES
- TREATED UNFAIRLY
- FREQUENT PAIN
- LOW ENERGY
- CONCENTRATION PROBLEMS
- RESTLESSNESS
- NAUSEA
- EATING DISORDER
- LEGAL DIFFICULTIES
- DRUG USE
- DRINKING PROBLEM
- BOREDOM
- HOPELESSNESS
- STRESS
- SHYNESS
- WORK PROBLEMS
- CONFUSION
- GUILT FEELINGS
- SUSPICION
- LONELINESS
- COMPULSIONS
- WORRY
- MONEY PROBLEMS
- DIFFICULTY WITH DECISIONS
- SPECIFIC FEARS
- MOURNING
- PHYSICAL ILLNESS
- POOR MOTIVATION
- FEELING ABANDONED
- MEANINGLESSNESS
- PERFECTIONISM
- UNUSUALLY SENSITIVE
- IRRITABILITY
- SOCIAL WITHDRAWAL
- FEELING MISUNDERSTOOD
- TROUBLESOME THOUGHTS
- RELIGIOUS CONCERNS
- DISAPPOINTMENT
- IMPULSIVE
- HEARING STRANGE VOICES
- FEELING INFERIOR
- IRRATIONAL THOUGHTS
- MOOD SWINGS

CHECK ALL YOU EXPERIENCED IN CHILDHOOD:

- HAPPY CHILDHOOD
- NEGLECTED
- MOVED FREQUENTLY
- PHYSICALLY ABUSED
- FEW FRIENDS
- SEXUALLY ABUSED
- WEIGHT PROBLEMS
- POPULAR
- PARENTS DIVORCED
- FAMILY FIGHTS
- POOR GRADES
- CONFLICT WITH TEACHER
- DRUG OR ALCOHOL USE
- GOOD GRADES
- SEXUAL PROBLEMS
- DEPRESSED
- 'SPOILED'
- ANXIOUS
- NOT ALLOWED TO GROW UP
- ATTENTION PROBLEMS
- ANGER PROBLEMS
- OTHER:_____
  _____
  _____
  _____

CURRENT LIVING SITUATION/RELATIONSHIP HISTORY

WHO LIVES WITH YOU NOW?
ARE YOU CURRENTLY MARRIED?
IF YES, FOR HOW LONG?
HOW MANY TIMES HAVE YOU BEEN MARRIED?
ARE YOU CURRENTLY IN A COMMITTED LONG-TERM RELATIONSHIP?
IF YES, FOR HOW LONG?
HOW MANY COMMITTED LONG-TERM RELATIONSHIPS HAVE YOU HAD?
BRIEFLY DESCRIBE ANY PROBLEMS IN YOUR CURRENT OR PAST ROMANTIC RELATIONSHIPS:

EDUCATION AND OCCUPATION INFORMATION

ARE YOU CURRENTLY...(CHECK ONE)

- WORKING
- IN SCHOOL
- BOTH
- NEITHER

HIGHEST LEVEL OF EDUCATION COMPLETED (CHECK ONE):

- GRADE SCHOOL
- HIGH SCHOOL
- TECHNICAL SCHOOL DIPLOMA IN: _____
- ASSOCIATE'S DEGREE IN: _____
- BACHELOR'S DEGREE IN: _____
- MASTER'S DEGREE IN: _____
- DOCTORAL DEGREE IN: _____

HOME LIFE/LEISURE TIME

HOW DO YOU SPEND YOUR PERSONAL TIME?
HOW MANY CONTACTS DO YOU HAVE EACH MONTH WITH FRIENDS OUTSIDE OF WORK OR SCHOOL?
WHO CAN YOU TALK WITH ABOUT PERSONAL FEELINGS OR PRIVATE MATTERS?
ARE YOUARE YOU SATISFIED WITH YOUR ROMANTIC LIFE?
WHY -OR- WHY NOT?

CHECK ALL YOU HAVE EXPERIENCED:

- RECENT SURGERY
- HEAD INJURY
- SEIZURES
- THYROID PROBLEMS
- DRUG/ALCOHOL ABUSE TREATMENT
- NEUROLOGICAL DISORDER
- CHRONIC PAIN
- HEADACHES
- DIABETES
- HORMONE PROBLEMS
- INFERTILITY
- MISCARRIAGES
- OTHER:

_____

HOW MANY HOURS DO YOU SLEEP/NIGHT ON AVERAGE?
HOW MANY ALCOHLIC BEVERAGES DO YOU CONSUME IN AN AVERAGE WEEK?
WHICH RECREATIONAL DRUGS HAVE YOU USED IN THE PAST YEAR?
HOW MUCH EXERCISE DO YOU GET IN AN AVERAGE WEEK?
WHAT KIND OF EXERCISE DO YOU DO REGULARLY?
DO YOU SMOKE OR USE TOBACCO?
PLEASE LIST ALL PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING AND THE REASONS YOU ARE TAKING THEM:

CLIENT SIGNATURE *DATE:*