

Welcome to my practice. I hope the experience is a positive one for you. To get the most out of counseling, I want to give you some quick tips about what to expect:

1. You'll need to fill out this intake packet first. Fill out the information sheet, read the consent form carefully and if you are coming for couples counseling, please have your partner sign the marriage and relationship consent form. Bring any questions that you might have into our first session.
2. The credit card payment consent form is attached for your convenience. As I accept debit and credit cards, this option makes it convenient for many clients to pay for their sessions this way, and takes the hassle out of it. I charge for each session after each session is completed. This is an optional form, and you can pay with cash or check if you choose.
3. Prior to our session, you may want to write some ideas about the things that you are struggling with and bring those into our first session. Sometimes clients like to put to paper the things that they want to work on. We'll create a treatment plan that includes those goals to work on our first session.
4. Our first session is an intake session. Although we will be talking about and highlighting the problems that brought you into counseling, it is not a formal counseling session. Usually, our second session begins the counseling process.
5. There is plenty of free parking in the main lot of the Chinese Cultural Center where my office is. You can park in that lot above ground, or there is an underground lot where you can also park. I am located on the third floor at 668 N. 44th St., inside of the Chinese Cultural Center, off of the 202 freeway on 44th St. just north of Van Buren. Please check in with the front office staff to notify them of your appointment with Jason.
6. On the street level, my office says "East Wing" on the front of the building. It's located next to the Golden Buddha restaurant, in the southeast corner of the Chinese Cultural Center. Suite 300 is the entire third floor of my office building, which is large, so please have a seat in the main lobby and I'll come get you. It will get confusing if you walk around looking for my particular room number, so find the lobby first.
7. If you have an evening session after 5:00 PM, be aware that the front office staff will not be there to greet you. Please exit the elevator on the third floor, and have a seat in the lobby. I will come to get you after my next session. If you have a 7:00 PM session, please be here 10 minutes early, as the front door locks for security and the elevator stops working. If you get here before seven, it'll be okay.

I look forward to working with you in our counseling sessions together, and please let me know if there is anything I can do to make your experience here in counseling better for you. Congratulations on making the step to get some help.

Jason Fierstein, MA, LPC
Counselor for Men and Couples

Jason Fierstein, MA, LPC 602.309.0568 jfierstein@mac.com

www.phoenixmencounseling.com
668 N. 44th Street, Suite 300, Phoenix, Arizona 85008

Information Sheet (First Person)

Please provide the information below. As always, your confidentiality is protected. Thank you.

Today's Date: _____

Last Name: _____ First: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home: _____ Work Phone: _____

E-mail Address (for appointment confirmation): _____

Employer/Occupation: _____

Birthdate: ____ / ____ / ____ Sex: _____ Age: _____ Marital Status: _____

Educational Background: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Do you have children? (If yes, list names/ages):

I am under a doctor's care for: _____

Doctor's name: _____

Doctor's phone number: _____

Medications currently taking: _____

May we send written materials to your home? **Y / N**

May we e-mail you? **Y / N**

May we leave a discreet message? **Y / N**

At your home phone? **Y / N**

At your work phone? **Y / N**

On your cell phone? **Y / N**

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Information Sheet (First Person) *continued*

Please provide the information below. As always, your confidentiality is protected. Thank you.

Would you like a free copy of the **Special Report: Ten Relationship Tactics to Go From Good To Great With Her** via e-mail? (You will also be subscribed to our newsletter, "Mentality" - published every four weeks, filled with practical tips and strategies for men and designed to help you and your relationship) **Y / N**

How did you hear about us? _____

On the internet? (Check if applicable.)

- | | |
|---|---|
| <input type="checkbox"/> Google | <input type="checkbox"/> Jason's Website |
| <input type="checkbox"/> AZCA | <input type="checkbox"/> Jewish News of Phoenix |
| <input type="checkbox"/> Psychology Today | <input type="checkbox"/> Find-a-Therapist.com |
| <input type="checkbox"/> Network Therapy | <input type="checkbox"/> LinkedIn |
| <input type="checkbox"/> Facebook/Twitter | <input type="checkbox"/> Other Website _____ |

Person who referred you:

May we thank this person for the referral? **Y / N**

Address of referrer: _____

What made you start coming to therapy at this time?

What do you see as the single biggest problem?

How do you manage stress? (hobbies, interests, types of exercise, relationships)

If therapy worked for you, what would be different?

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Information Sheet (Second Person)

Please provide the information below. As always, your confidentiality is protected. Thank you.

Today's Date: _____

Last Name: _____ First: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home: _____ Work Phone: _____

E-mail Address (for appointment confirmation): _____

Employer/Occupation: _____

Birthdate: ____ / ____ / ____ Sex: _____ Age: _____ Marital Status: _____

Educational Background: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Do you have children? (If yes, list names/ages):

I am under a doctor's care for: _____

Doctor's name: _____

Doctor's phone number: _____

Medications currently taking: _____

May we send written materials to your home? **Y / N**

May we e-mail you? **Y / N**

May we leave a discreet message? **Y / N**

At your home phone? **Y / N**

At your work phone? **Y / N**

On your cell phone? **Y / N**

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Information Sheet (Second Person) *continued*

Please provide the information below. As always, your confidentiality is protected. Thank you.

Would you like a free copy of the **Special Report: Ten Relationship Tactics to Go From Good To Great With Her** via e-mail? (You will also be subscribed to our newsletter, "Mentality" - published every four weeks, filled with practical tips and strategies for men and designed to help you and your relationship) **Y / N**

How did you hear about us? _____

On the internet? (Check if applicable.)

- | | |
|---|---|
| <input type="checkbox"/> Google | <input type="checkbox"/> Jason's Website |
| <input type="checkbox"/> AZCA | <input type="checkbox"/> Jewish News of Phoenix |
| <input type="checkbox"/> Psychology Today | <input type="checkbox"/> Find-a-Therapist.com |
| <input type="checkbox"/> Network Therapy | <input type="checkbox"/> LinkedIn |
| <input type="checkbox"/> Facebook/Twitter | <input type="checkbox"/> Other Website _____ |

Person who referred you:

May we thank this person for the referral? **Y / N**

Address of referrer: _____

What made you start coming to therapy at this time?

What do you see as the single biggest problem?

How do you manage stress? (hobbies, interests, types of exercise, relationships)

If therapy worked for you, what would be different?

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Credit Card Payment Consent Form

Patient Name: _____
Print Last Name *First Name* *Middle Initial*

Name on Card (if different): _____

I authorize Jason S. Fierstein, and Intuit GoPayment Merchant Services, to charge my credit/debit card for professional services as follows:
Please Initial

- _____ This visit only, for the amount of \$ _____
- _____ All visits in the next 12 months, beginning ____ / ____ / ____ , not to exceed \$ _____ total.
- _____ Recurring charges, date(s) of service ____ / ____ / ____ to ____ / ____ / ____ , not to exceed \$ _____ ,
_____ monthly, _____ semimonthly, _____ weekly, _____ per visit.

Type of Card: Visa MasterCard Discover AMEX Medical Savings/Expense

Credit Card Number _____ - _____ - _____ - _____

CVV Number _____

*A 3-digit number in reverse italics
on the **back** of the credit card.*

Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

Street *City* *State* *Zip*

Card holder Signature _____ Date ____ / ____ / ____

*Charges will appear on your credit card
as **Intuit GoPayment Merchant
Services** or some abbreviation of it.*

Intuit GoPayment | <http://gopayment.com> | (888) 486-9795

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Symptoms (First Person)

Put a number next to any item which you experience.

1 = mildly

2 = moderately

3 = severely

Emotional Concerns

- | | | |
|---|--|--|
| <input type="checkbox"/> feeling anxious or uptight | <input type="checkbox"/> excessive worrying | <input type="checkbox"/> not being able to relax |
| <input type="checkbox"/> feeling panicky | <input type="checkbox"/> unable to calm yourself down | <input type="checkbox"/> dwelling on certain thoughts or images |
| <input type="checkbox"/> fearing something terrible about to happen | <input type="checkbox"/> avoiding certain thoughts or feelings | <input type="checkbox"/> having strong fears |
| <input type="checkbox"/> worrying about a nervous breakdown | <input type="checkbox"/> feeling out of control | <input type="checkbox"/> avoiding being with people |
| <input type="checkbox"/> fears of being alone or abandoned | <input type="checkbox"/> feeling guilty | <input type="checkbox"/> having nightmares |
| <input type="checkbox"/> flashbacks | <input type="checkbox"/> troubling or painful memories | <input type="checkbox"/> missing periods of time—can't remember |
| <input type="checkbox"/> trouble remembering things | <input type="checkbox"/> feeling numb instead of upset | <input type="checkbox"/> feeling detached from all or part of body |
| <input type="checkbox"/> feeling unreal, strange or foggy | <input type="checkbox"/> feeling depressed or sad | <input type="checkbox"/> being tired or lacking energy |
| <input type="checkbox"/> feeling unmotivated | <input type="checkbox"/> loss of interest in many things | <input type="checkbox"/> having trouble concentrating |
| <input type="checkbox"/> having trouble making decisions | <input type="checkbox"/> feeling the future looks hopeless | <input type="checkbox"/> feeling worthless or a failure |
| <input type="checkbox"/> being unhappy all the time | <input type="checkbox"/> dissatisfied with physical appearance | <input type="checkbox"/> feeling self critical or blaming yourself |
| <input type="checkbox"/> having negative thoughts | <input type="checkbox"/> crying often | <input type="checkbox"/> feeling empty |
| <input type="checkbox"/> withdrawing inside yourself | <input type="checkbox"/> thinking too much about death | <input type="checkbox"/> thoughts of hurting yourself |
| <input type="checkbox"/> thoughts of killing yourself | <input type="checkbox"/> frequent mood swings | <input type="checkbox"/> feeling resentful or angry |
| <input type="checkbox"/> feeling irritable or frustrated | <input type="checkbox"/> feeling rage | <input type="checkbox"/> feeling like hurting someone |

Behavioral and Physical Concerns

- | | | |
|---|--|---|
| <input type="checkbox"/> not having an appetite | <input type="checkbox"/> eating in binges | <input type="checkbox"/> self induced vomiting for weight control |
| <input type="checkbox"/> using laxatives for weight control | <input type="checkbox"/> eating too much | <input type="checkbox"/> eating too little |
| <input type="checkbox"/> losing weight—how much? _____ | <input type="checkbox"/> gaining weight—how much? _____ | <input type="checkbox"/> trouble sleeping |
| <input type="checkbox"/> trouble falling asleep | <input type="checkbox"/> early morning awakening | <input type="checkbox"/> sleeping too much |
| <input type="checkbox"/> sleeping too little | <input type="checkbox"/> # of hours I usually sleep: _____ | <input type="checkbox"/> lack of exercise |
| <input type="checkbox"/> not having leisure activities | <input type="checkbox"/> smoking cigarettes | <input type="checkbox"/> often spending in binges |
| <input type="checkbox"/> temper outbursts | <input type="checkbox"/> aggressive toward others | <input type="checkbox"/> impulsive reactions |
| <input type="checkbox"/> trouble finishing things | <input type="checkbox"/> working too hard | <input type="checkbox"/> using alcohol too much |
| <input type="checkbox"/> being alcoholic | <input type="checkbox"/> using drugs | <input type="checkbox"/> driving under the influence |
| <input type="checkbox"/> blackouts—after drinking | | |

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever felt you ought to cut down on your drinking or drug use? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have people annoyed you by criticizing your drinking or drug use? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever felt bad or guilty about your drinking or drug use? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? |

Sexual Concerns

- | | | |
|--|--|--|
| <input type="checkbox"/> worrying about getting pregnant | <input type="checkbox"/> having miscarriage(s) | <input type="checkbox"/> choice of birth control |
| <input type="checkbox"/> having an abortion | <input type="checkbox"/> not able to become pregnant | <input type="checkbox"/> not enjoying sexual affection |
| <input type="checkbox"/> too tired to have sex | <input type="checkbox"/> too anxious to have sex | <input type="checkbox"/> feeling a lack of sexual desire |
| <input type="checkbox"/> wanting to have sex more often | <input type="checkbox"/> feeling neglected sexually | <input type="checkbox"/> feeling used sexually |
| <input type="checkbox"/> feeling unable to have orgasm | <input type="checkbox"/> being unable to sustain an erection | <input type="checkbox"/> feeling negatively about sex |

Directions (First Person)

Put a number next to any item which you experience.

1 = mildly

2 = moderately

3 = severely

Intimate Relationship Concerns

- | | | |
|--|---|--|
| <input type="checkbox"/> lack of fairness in relationship | <input type="checkbox"/> problems with dividing household tasks | <input type="checkbox"/> disagreeing about children |
| <input type="checkbox"/> lack of affection | <input type="checkbox"/> unsatisfactory sexual relationship | <input type="checkbox"/> lack of time together |
| <input type="checkbox"/> lack of shared interests | <input type="checkbox"/> lack of positive interaction | <input type="checkbox"/> lack of time with other couples |
| <input type="checkbox"/> jealousy in relationship | <input type="checkbox"/> frequent arguments | <input type="checkbox"/> trouble resolving conflict |
| <input type="checkbox"/> partner being demanding and controlling | <input type="checkbox"/> partner putting you down | <input type="checkbox"/> violent arguments |
| <input type="checkbox"/> emotional abuse in relationship | <input type="checkbox"/> physical abuse in relationship | <input type="checkbox"/> sexual abuse in relationship |
| <input type="checkbox"/> partner having alcohol or drug problem | <input type="checkbox"/> self or partner having an affair | <input type="checkbox"/> feeling uncommitted to relationship |
| <input type="checkbox"/> wanting to separate | <input type="checkbox"/> discussing separating or divorce | <input type="checkbox"/> problems with in-laws |
| <input type="checkbox"/> problems with ex-partner | <input type="checkbox"/> problems with step parents | <input type="checkbox"/> children having special problems |
| <input type="checkbox"/> sexual abuse in relationship | | |

When Growing Up to Present Time:

- | | | |
|--|--|--|
| <input type="checkbox"/> being physically abused—by whom? | <input type="checkbox"/> being emotionally abused—by whom? | <input type="checkbox"/> being sexually abused—by whom? |
| <input type="checkbox"/> having an alcoholic parent—which? | <input type="checkbox"/> having a drug abusing parent—which? | <input type="checkbox"/> having a depressed parent—which? |
| <input type="checkbox"/> having a parent with emotional problems | <input type="checkbox"/> having parents separate or divorce | <input type="checkbox"/> close family member dying—who? |
| <input type="checkbox"/> felt neglected or unloved—by whom | <input type="checkbox"/> having an unhappy childhood | <input type="checkbox"/> having serious medical problems—what? |
| <input type="checkbox"/> having drug or alcohol problem | <input type="checkbox"/> frequent moves | <input type="checkbox"/> having learning problems—what? |
| <input type="checkbox"/> having emotional problems | <input type="checkbox"/> having attempted suicide—when? | |

Stresses During the Past Several Years:

- | | | |
|--|--|--|
| <input type="checkbox"/> death of family member or friend - who? | <input type="checkbox"/> birth or adoption of child | <input type="checkbox"/> self or family member hospitalized—who? |
| <input type="checkbox"/> moved | <input type="checkbox"/> being harassed or assaulted | <input type="checkbox"/> frequent family or couple arguments |
| <input type="checkbox"/> separation/divorce | <input type="checkbox"/> an important relationship ending—who? | <input type="checkbox"/> losing or changing job |
| <input type="checkbox"/> financial trouble | <input type="checkbox"/> legal problems | <input type="checkbox"/> natural disaster |

serious or chronic illness—what: _____

other _____

Please State Your Goals for Therapy:

1. _____

2. _____

3. _____

Additional Comments:

Symptoms (Second Person)

Put a number next to any item which you experience.

1 = mildly

2 = moderately

3 = severely

Emotional Concerns

- | | | |
|---|--|--|
| <input type="checkbox"/> feeling anxious or uptight | <input type="checkbox"/> excessive worrying | <input type="checkbox"/> not being able to relax |
| <input type="checkbox"/> feeling panicky | <input type="checkbox"/> unable to calm yourself down | <input type="checkbox"/> dwelling on certain thoughts or images |
| <input type="checkbox"/> fearing something terrible about to happen | <input type="checkbox"/> avoiding certain thoughts or feelings | <input type="checkbox"/> having strong fears |
| <input type="checkbox"/> worrying about a nervous breakdown | <input type="checkbox"/> feeling out of control | <input type="checkbox"/> avoiding being with people |
| <input type="checkbox"/> fears of being alone or abandoned | <input type="checkbox"/> feeling guilty | <input type="checkbox"/> having nightmares |
| <input type="checkbox"/> flashbacks | <input type="checkbox"/> troubling or painful memories | <input type="checkbox"/> missing periods of time—can't remember |
| <input type="checkbox"/> trouble remembering things | <input type="checkbox"/> feeling numb instead of upset | <input type="checkbox"/> feeling detached from all or part of body |
| <input type="checkbox"/> feeling unreal, strange or foggy | <input type="checkbox"/> feeling depressed or sad | <input type="checkbox"/> being tired or lacking energy |
| <input type="checkbox"/> feeling unmotivated | <input type="checkbox"/> loss of interest in many things | <input type="checkbox"/> having trouble concentrating |
| <input type="checkbox"/> having trouble making decisions | <input type="checkbox"/> feeling the future looks hopeless | <input type="checkbox"/> feeling worthless or a failure |
| <input type="checkbox"/> being unhappy all the time | <input type="checkbox"/> dissatisfied with physical appearance | <input type="checkbox"/> feeling self critical or blaming yourself |
| <input type="checkbox"/> having negative thoughts | <input type="checkbox"/> crying often | <input type="checkbox"/> feeling empty |
| <input type="checkbox"/> withdrawing inside yourself | <input type="checkbox"/> thinking too much about death | <input type="checkbox"/> thoughts of hurting yourself |
| <input type="checkbox"/> thoughts of killing yourself | <input type="checkbox"/> frequent mood swings | <input type="checkbox"/> feeling resentful or angry |
| <input type="checkbox"/> feeling irritable or frustrated | <input type="checkbox"/> feeling rage | <input type="checkbox"/> feeling like hurting someone |

Behavioral and Physical Concerns

- | | | |
|---|--|---|
| <input type="checkbox"/> not having an appetite | <input type="checkbox"/> eating in binges | <input type="checkbox"/> self induced vomiting for weight control |
| <input type="checkbox"/> using laxatives for weight control | <input type="checkbox"/> eating too much | <input type="checkbox"/> eating too little |
| <input type="checkbox"/> losing weight—how much? _____ | <input type="checkbox"/> gaining weight—how much? _____ | <input type="checkbox"/> trouble sleeping |
| <input type="checkbox"/> trouble falling asleep | <input type="checkbox"/> early morning awakening | <input type="checkbox"/> sleeping too much |
| <input type="checkbox"/> sleeping too little | <input type="checkbox"/> # of hours I usually sleep: _____ | <input type="checkbox"/> lack of exercise |
| <input type="checkbox"/> not having leisure activities | <input type="checkbox"/> smoking cigarettes | <input type="checkbox"/> often spending in binges |
| <input type="checkbox"/> temper outbursts | <input type="checkbox"/> aggressive toward others | <input type="checkbox"/> impulsive reactions |
| <input type="checkbox"/> trouble finishing things | <input type="checkbox"/> working too hard | <input type="checkbox"/> using alcohol too much |
| <input type="checkbox"/> being alcoholic | <input type="checkbox"/> using drugs | <input type="checkbox"/> driving under the influence |
| <input type="checkbox"/> blackouts—after drinking | | |

- Yes No Have you ever felt you ought to cut down on your drinking or drug use?
- Yes No Have people annoyed you by criticizing your drinking or drug use?
- Yes No Have you ever felt bad or guilty about your drinking or drug use?
- Yes No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Sexual Concerns

- | | | |
|--|--|--|
| <input type="checkbox"/> worrying about getting pregnant | <input type="checkbox"/> having miscarriage(s) | <input type="checkbox"/> choice of birth control |
| <input type="checkbox"/> having an abortion | <input type="checkbox"/> not able to become pregnant | <input type="checkbox"/> not enjoying sexual affection |
| <input type="checkbox"/> too tired to have sex | <input type="checkbox"/> too anxious to have sex | <input type="checkbox"/> feeling a lack of sexual desire |
| <input type="checkbox"/> wanting to have sex more often | <input type="checkbox"/> feeling neglected sexually | <input type="checkbox"/> feeling used sexually |
| <input type="checkbox"/> feeling unable to have orgasm | <input type="checkbox"/> being unable to sustain an erection | <input type="checkbox"/> feeling negatively about sex |

Symptoms (Second Person)

Put a number next to any item which you experience.

1 = mildly

2 = moderately

3 = severely

Intimate Relationship Concerns

- | | | |
|--|---|--|
| <input type="checkbox"/> lack of fairness in relationship | <input type="checkbox"/> problems with dividing household tasks | <input type="checkbox"/> disagreeing about children |
| <input type="checkbox"/> lack of affection | <input type="checkbox"/> unsatisfactory sexual relationship | <input type="checkbox"/> lack of time together |
| <input type="checkbox"/> lack of shared interests | <input type="checkbox"/> lack of positive interaction | <input type="checkbox"/> lack of time with other couples |
| <input type="checkbox"/> jealousy in relationship | <input type="checkbox"/> frequent arguments | <input type="checkbox"/> trouble resolving conflict |
| <input type="checkbox"/> partner being demanding and controlling | <input type="checkbox"/> partner putting you down | <input type="checkbox"/> violent arguments |
| <input type="checkbox"/> emotional abuse in relationship | <input type="checkbox"/> physical abuse in relationship | <input type="checkbox"/> sexual abuse in relationship |
| <input type="checkbox"/> partner having alcohol or drug problem | <input type="checkbox"/> self or partner having an affair | <input type="checkbox"/> feeling uncommitted to relationship |
| <input type="checkbox"/> wanting to separate | <input type="checkbox"/> discussing separating or divorce | <input type="checkbox"/> problems with in-laws |
| <input type="checkbox"/> problems with ex-partner | <input type="checkbox"/> problems with step parents | <input type="checkbox"/> children having special problems |
| <input type="checkbox"/> sexual abuse in relationship | | |

When Growing Up to Present Time:

- | | | |
|--|--|--|
| <input type="checkbox"/> being physically abused—by whom? | <input type="checkbox"/> being emotionally abused—by whom? | <input type="checkbox"/> being sexually abused—by whom? |
| <input type="checkbox"/> having an alcoholic parent—which? | <input type="checkbox"/> having a drug abusing parent—which? | <input type="checkbox"/> having a depressed parent—which? |
| <input type="checkbox"/> having a parent with emotional problems | <input type="checkbox"/> having parents separate or divorce | <input type="checkbox"/> close family member dying—who? |
| <input type="checkbox"/> felt neglected or unloved—by whom | <input type="checkbox"/> having an unhappy childhood | <input type="checkbox"/> having serious medical problems—what? |
| <input type="checkbox"/> having drug or alcohol problem | <input type="checkbox"/> frequent moves | <input type="checkbox"/> having learning problems—what? |
| <input type="checkbox"/> having emotional problems | <input type="checkbox"/> having attempted suicide—when? | |

Stresses During the Past Several Years:

- | | | |
|--|--|--|
| <input type="checkbox"/> death of family member or friend - who? | <input type="checkbox"/> birth or adoption of child | <input type="checkbox"/> self or family member hospitalized—who? |
| <input type="checkbox"/> moved | <input type="checkbox"/> being harassed or assaulted | <input type="checkbox"/> frequent family or couple arguments |
| <input type="checkbox"/> separation/divorce | <input type="checkbox"/> an important relationship ending—who? | <input type="checkbox"/> losing or changing job |
| <input type="checkbox"/> financial trouble | <input type="checkbox"/> legal problems | <input type="checkbox"/> natural disaster |

serious or chronic illness—what: _____

other _____

Please State Your Goals for Therapy:

1. _____

2. _____

3. _____

Additional Comments:

Informed Consent for Assessment & Treatment

Informed Consent for Assessment and Treatment

Welcome to my counseling practice. I am committed to getting you whatever your outcome is for our time together. A counseling situation offers a unique relationship between the two of us. In order that we start our relationship in a healthy way, I have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling and psychotherapy services.

Background and Services

I am a professional counselor in an independent private counseling practice. My credentials include a Masters degree in psychology, and I am licensed by the Arizona Board of Behavioral Health. Additional information about my background is available on my website at www.phoenixmencounseling.com.

I offer counseling and psychotherapy services to individuals and couples in the areas of mental health, relationships, adjustment, personal development and career and business issues.

The primary focus of my practice is adults. Clients that present in counseling with active substance abuse dependence, eating disorders, sexually abusive or violent behaviors, severe mental disorders, or certain personality disorders as their primary problem will be referred to other professionals or programs that specialize in these areas.

I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs or desires in therapy are not a good match for my skills or experience.

Financial

Payment is expected at the time the service is rendered unless other arrangements have been made. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. Currently, the fee for an initial intake and assessment (50 minutes long) is \$150 (an hour and 40 minute couples intake/assessment is \$300) and the fee for a 50 minute individual counseling session is \$150. The fee for a 50 minute couples session is also \$150.

Sometimes, counseling sessions do extend longer than the allotted 50-minute hour, and I charge on a pro-rated basis at that point (\$150/hour prorated). If our session is ending at the 50-minute mark, I will ask your permission to continue in our session if we are in the middle of our work together. If you agree to extend the session, I will start charging on that prorated basis from that point on until the end of the session.

In addition to the basic session and assessment fees, there may be other fees for additional services such as psychometric testing, telephone counseling, books and materials, phone conversations with lawyers, doctors, or other professionals, etc. The basic fees are posted in my office, and fee information for those not listed is available upon request. I reserve the right to change my fees with 30 days notice and to use the services of a third-party collections service, when necessary. Refunds are not made after the services have been rendered. You have the right to be informed of all fees that you are required to pay and my refund and collection policies. If your check is returned to me for insufficient funds, you will be required to promptly pay me back for both the cost of your unpaid session and a returned check fee of \$12. Please discuss these with me if you have a concern.

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668 N. 44th Street, Suite 300, Phoenix, Arizona 85008

Informed Consent for Assessment & Treatment *continued*

Insurance.

I am a fee-for-service counselor, and although I do not accept insurance, I will supply you with a superbill that you can turn into your insurance company so they can reimburse you. You must contact your insurance company to understand the terms of your policy, including out-of-network reimbursement. In all cases however, payment for services is ultimately the responsibility of the client, not the insurance company. Once again, please discuss this with me if you have questions or concerns about using your insurance.

If you are over 65, or otherwise eligible for Medicare you should understand that Licensed Professional Counselors are not currently eligible providers under this program. Medicare clients are required to pay the fees out of pocket, even if I am a covered provider under a secondary insurance plan.

Your insurance company or managed care company may limit the number of sessions based on their assessment of medical necessity or other factors. Their determination may or may not match what you want or need in treatment. In the event that they will not authorize additional sessions or you exhaust the sessions that your insurance will provide, you understand that you will have to pay for the additional services rendered.

Using a third party to pay for the counseling implies that some information will be released in order to obtain payment for the services. Please see the HIPAA NOTICE OF PRIVACY PRACTICES for more information.

Availability of services

My practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to the local hotlines (Empact – 480-784-1500, Banner Help line - 602-254-4357, Magellan – 602-222-9444). Established clients with an urgent need to make contact may call or e-mail me, but an immediate response is not guaranteed. I do attempt to get back to you by the end of the day, or soon after. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation. There may be extended lengths of time (days) when I am not available by phone or any other means. If you need a counselor that is readily available, please let me know by our first session so that I can refer you to an appropriate professional.

Appointments

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve an hour or more for each appointment with a client. Appointments cancelled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday; weekend calls do not count) prior to your appointment if you need to cancel. You will be charged for appointments you fail to cancel in accordance with this policy. Currently, the late cancellation fee charged for this is \$75 (\$150 for a couples intake or for a two-hour counseling session). Repeated late cancellations or missed appointments will be billed at the full fee of \$150, depending on the service scheduled, and may result in termination of treatment. In addition, if you arrive more than 20 minutes late to an appointment, that is considered a missed appointment, and you will be charged full fee for the session. If you have a credit card on file, I will first notify you by phone or email, and then charge your card automatically for the session.

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Informed Consent for Assessment & Treatment *continued*

Appointments *continued*

If you call or e-mail to cancel your appointment after it has already begun, this will be considered a no call/no-show, and you will be charged and responsible for the full fee of \$150 for the missed session. Please note that these are personal financial obligations that you are responsible for, not the obligations of your insurance company. Appointment availability varies with the client load at the time. High demand appointments (off hours, late afternoons, evenings) are likely to be sporadic in their availability. I reserve the right to limit my commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload.

Privacy, confidentiality, and records

Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statutes. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved. I will break confidentiality if there is a threat to of harm to yourself or to someone else, or if you are homicidal or suicidal. I also participate in a process where selected cases are discussed with other professional colleagues to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods.

It is important to be aware that I use a number of electronic tools in my practice, including computers and the internet, email, PDA, fax machines, telephones, and a cell phone. I may use these tools to store or communicate information about you and your treatment. While reasonable backup, security, and other safeguards are in place, there is always some risk of inadvertent disclosure of information that comes with using these tools. By signing this informed consent, you agree to accept the risk of disclosure that comes with tools that I use in my practice.

There are also numerous other circumstances when information may be released including but not limited to when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against me, to comply with worker compensation laws, to comply with the USA Patriot Act and to comply with other federal, state or local laws. The rules and laws regarding confidentiality, privacy, and records are complex. The *HIPAA NOTICE OF PRIVACY PRACTICES*, included in this packet of information, details the considerations regarding confidentiality, privacy, and your records. This packet also contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so. Periodically, the *HIPAA NOTICE OF PRIVACY PRACTICES* may be revised. It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.

Initials

I have read the *HIPAA NOTICE OF PRIVACY PRACTICES*, and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the *HIPAA NOTICE OF PRIVACY PRACTICES* is incorporated by reference into this agreement.

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Informed Consent for Assessment & Treatment *continued*

Privacy, confidentiality, and records *continued*

In the event of my death, retirement, or incapacity, the records for my clients that are actively receiving services (seen within the last month) will be given to one or more local behavioral health professionals to facilitate the continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by a “records custodian,” which may be an individual or company. The custodian will be responsible for satisfying records requests and destroying records when the legal timeframes for records retention are satisfied.

Purpose, limitations, and risks of treatment

Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful.

Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy may result in changes that were not originally intended.

Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. Of course, the potential for a divorce is always a risk in marital counseling.

I practice Gestalt Therapy, which is one orientation to counseling. I use experiments in our counseling sessions, such as the empty chair technique, which may bring up emotional or psychological pain for you, the client. I want to communicate that sometimes working through these painful experiences can be difficult, and you have the right to communicate your wish to discontinue treatment if the counseling becomes too overwhelming for you at any time.

In most cases, one or more mental health diagnoses will be rendered during the process of assessment and treatment. Some diagnoses may affect employment in high security or safety sensitive positions or affect your ability to obtain future insurance.

Treatment process and rights

Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal.

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Informed Consent for Assessment & Treatment *continued*

Treatment process and rights *continued*

Termination of Counseling. I want you to know that one of my policies is to support all termination, for whatever reason. When you are ready to leave, I would like to help you leave well. Here are my suggestions to make that happen. Communicate with me that you feel you are ready to end counseling, and we will meet for a closure session, or a final session to review what has worked in counseling for you, and what issues might need more attention in the future. There will be no hard feelings about ending counseling if you choose to discontinue treatment. If you need referrals elsewhere to other providers, I can provide you with those as well. Let's talk about that in our closure session when you're ready to end treatment.

Litigation considerations. If you become involved in the legal system (divorce, custody, civil litigation, criminal activity, etc.) you can expect that I will not make recommendations, testify, or get otherwise involved in your legal activities. It is an inherent conflict of interest for a treating professional to also offer evaluations or opinions in legal matters. If a client has these expectations, it can affect their willingness to disclose personal information vital to treatment. If you need an evaluation for the legal reasons, I will make a referral to an outside, unbiased professional who can perform this service. In signing this agreement, you agree that you will not call me as a witness to testify or to expect recommendations or other involvement in your legal activities.

Our relationship

The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, or to bestow gifts. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained.

Furthermore, trust is an essential part of the therapeutic relationship. If there are situations that arise that compromise this trust, I will first talk about the situation with you in our counseling. If the situation cannot be resolved, I reserve the right to discontinue therapy and refer you to another provider that can help you. Maintaining proper boundaries with the therapist is essential to the counseling process; such examples of compromised boundaries include, but are not limited to, seeking rental or office space in the suite in which I currently practice.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

Consent for evaluation and treatment

Consent is hereby given for evaluation and treatment under the terms described in this consent document and the *HIPAA NOTICE OF PRIVACY PRACTICES*. I acknowledge that I have received a copy of this informed consent agreement and the *HIPAA NOTICE OF PRIVACY PRACTICES*. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature: _____ Date: _____

Signature: _____ Date: _____

In the case of minor children, please specify the following:

Full name of minor: _____ DOB _____ Relationship _____

For office use only — verification that client has read and understands informed consent document.

Authorized Representative:

Date:

HIPAA Statement

This Notice Describes How Health Information About You May Be Used And Disclosed And How You Can Get Access To This Information.

Please Review It Carefully. The Privacy Of Your Health Information Is Important To Us.

What is HIPAA and PHI?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits the release of PHI without patient authorization for purposes of treatment, payment and health care operations. However, the HIPAA Privacy Rule requires that providers make reasonable effort to disclose only the minimum amount of PHI that is necessary for these purposes.

PHI is any individually identifiable health information relating to a patient's past, present or future physical or mental health and related health care services. PHI may include demographics, documentation of symptoms, examination and test results, diagnoses and treatments.

Written authorization is not needed to send copies of a patient's medical records to a specialist or other health care provider who is treating him or her. Providers are allowed to disclose PHI to primary care managers and other health care providers for treatment purposes. PHI may also be disclosed without the patient's authorization in a medical emergency to provide the necessary treatment.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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HIPAA Statement *continued*

Uses And Disclosures of Health Information

We use and disclose health information about you for treatment, payment and healthcare options. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessarily to help with our healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your healthcare, of your location, your general conditions, or death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up filled prescriptions, medical supplies, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

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Informed Consent Supplement for Marriage & Relationships

For couples only.

In addition to the provisions of the Informed Consent document that you have already signed, there are a few special things that you need to know about marriage, family, and relationship counseling.

The most important of these is some change to the confidentiality provisions of our time together. When I do couples or family therapy, I keep one record for the session. The regulations in the state of Arizona specify that information about a counseling session that is attended by more than one legal adult may not be released without the written authorization of all the legal adults that attended the session. That means if you as an individual ever want a copy of your records or information from a marriage, family, or relationship counseling session, it will require the written approval of all the legal adults that attended the session.

You should also know a bit about my philosophy of couples counseling. I believe that it is very important to maintain an open, honest, balanced relationship with both parties as we proceed through the counseling process. If I receive a telephone call, fax, email or any other form of communication from one of the individuals, the partner will be notified of that communication at the next session and we will process the information discussed. In signing this document, you are expressly waiving any confidentiality between us to allowing me to discuss those issues with your partner.

Sometimes, individual sessions are warranted with one partner or the other. The information from that session may be available for the partner not present at the next couples session. In couples counseling, I encourage honesty and disclosure, and realize that clients sometimes need an individual session to work through what is difficult to say to their partner. Again, that information may be available for the partner not present, as both of you have entered into the couples counseling session together. If either one of you feels not taken care of, or feel like you're losing me, or an alliance is developing, please let me know, so we can bring someone else into the couples' work. Please be aware of this important addendum.

Consent for evaluation and treatment. Consent is hereby given for evaluation and treatment under the terms described in this consent document.

Signature: _____ Date: _____

Signature: _____ Date: _____

For office use only — verification that client has read and understands informed consent document.

Authorized Representative: _____ Date: _____

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