**Thunderbird Oasis Counseling**

18205 N 51st Ave #113

Glendale, AZ 85308

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_ M\_\_ F\_\_

Phone(hm):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status: (circle) single married domestic partner

legally separated divorced widowed

Work number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to call? Y or N Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Employer/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client’s occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ SSN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Authorization #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent to Treatment:**

**I voluntarily consent to the examination, treatment and procedures which may be performed as part of my**

**care or the care of my minor child by my therapist. Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby authorize Jennifer Slothower, MS, LPC to release to any appropriate insurance related entity or collection**

**agency the information needed to process claims for payment in reference to my treatment. Initial \_\_\_\_\_\_\_\_**

**Signature of Patient, Parent, or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

THUNDERBIRD OASIS COUNSELING

Psychosocial History

**Client Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_

What brings you in today? (symptoms & brief history):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current relationship status? (married, divorced, dating, widowed, etc – how long) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who are the members of your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your educational level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/school information/status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any current economic or financial stresses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom do you socialize with? Doing what leisure activities?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any significant Cultural/Spiritual influences in your life?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you having any issues with sexuality or intimacy? (including pregnancy issues) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any Medical Conditions? Are you currently on ANY medication (including over the counter, vitamins, herbs,etc)? Do you have any allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any previous mental health treatment or counseling? If so with whom, where, when & how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you now have (or have you ever had) a substance abuse problem and/or treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you experiencing any legal issues?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your current strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Clinician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Glendale, AZ 85308

***Informed Consent to Treatment:***

Please read and initial in the designated spaces that you have read and understand the material and agree to the

conditions set forth herein:

I hereby authorize the staff /therapist to notify the referral source (if he or she is a professional) of my having

made this appointment. This alone will be disclosed to the referring professional and is done only as a professional

courtesy. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the purpose of treatment is to restore and improve functional behavioral health through therapeutic modalities including but not limited to individual and/or family therapy, cognitive behavioral interventions, and

encouraging the use of community resources and informal supports. Initial \_\_\_\_\_\_\_\_\_\_\_\_

I am aware that I may stop treatment at any time. I understand that no promises have been made to me as to the results of treatment or recommendations provided by a TOC therapist. Initial \_\_\_\_\_\_\_\_\_\_\_\_

I understand that by terminating services against the advice of my treatment team, I may not fully benefit from resolution

of symptoms for which I sought treatment. Initial \_\_\_\_\_\_\_\_\_\_\_\_

I am aware that it is my responsibility to discuss concerns of care with my therapist. If issues remain unresolved

and are believed to be an ethical or legal violation of the therapeutic contract, I may file a complaint through my

behavioral health insurance company and/or the Arizona Board of Behavioral Health Examiners. Initial \_\_\_\_\_\_

I understand that payment is due in full at the time of service. Should my account become delinquent and be referred to any

third party for collection effort, I agree to pay all reasonable attorney’s fees, court costs, and a collection expense of not more

than 30 percent of referred balance. I also understand that my therapist reserves the right to suspend/terminate services until

overdue balances are paid. I understand that if any questions should arise concerning the status of my account; I have the

responsibility to direct such inquiries to my therapist. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that a TOC therapist may determine that additional or specialized treatment is clinically necessary (such as

psychiatric services and/or medication). In the event that TOC is unable to provide that treatment, the therapist will suggest

appropriate referrals or alternatives. I am free to choose my own treatment or decline further treatment services. In addition,

understand that TOC is not responsible for the cost of any recommended treatment. Initial \_\_\_\_\_\_\_\_\_\_\_\_

I authorize the payment of my insurance benefits directly to my therapist on my behalf. I understand I am

responsible for all deductibles, co-insurance and non-covered charges. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that patients are seen on appointment only and that any cancellations of appointment not made a

minimum of 24 hours in advance of the scheduled time will incur a fee equal to my regular fee rate for my

therapist. (**Please note most insurances do not reimburse for missed appointments.**) Initial\_\_\_\_\_\_\_\_\_\_\_\_

I understand that therapist time devoted to offering testimony in deposition for legal concerns will be compensated

at the regular hourly rate paid by your insurance benefits. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOC - Informed Consent -2-

I understand that my therapeutic sessions are completely protected by federal confidentiality laws ***with the***

***following exceptions:***

1. If any person being treated threatens violence or harm to him/herself and/or to another person,

the appropriate authorities will be contacted to insure the safety of all concerned parties.

1. If reason arises during treatment to suspect ongoing child/elder abuse, this will be reported to

the appropriate authorities.

1. If a court of law issues a Court Order to release information the therapist must comply.
2. Your therapist may receive consultation or supervision from another professional. If so, your

case may be discussed confidentially with this supervising professional.

Information about your case will not be disclosed without your prior, written permission except in the above instances. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Emergencies:***

Your therapist is available for emergencies 24 hours/day. You have the cell phone of your therapist and are urged to call should a crisis arise. Please remember you and your therapist are a team to empower and activate your own innate

strengths and knowledge for living effectively. You are always the agent of change in the moment and therefore, your therapist is available after you feel you have exhausted your own resources and would benefit from contact with her. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your therapist is on vacation, there will be someone covering the practice and this person will cover emergencies while the vacation is happening. If you feel you need more immediate intensive services, call 911 or go the closest Emergency Department. There is also a Behavioral Health facility at Banner Thunderbird to assist with an emergency situation. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign below and date to indicate you have read and understand the above and agree to those arrangements outlined concerning your treatment. You have the right to request a copy of this document for your records.

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party (if different than patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Client Rights and Responsibilities**

**As a client, you have the right:**

**To receive services:**

* That respect your privacy and dignity
* That are provided in a prompt, courteous, and respectful manner
* That respect your cultural and ethnic identity, religion, disability, gender, age, marital status, and sexual orientation
* That are provided in a physical environment that is safe, sanitary, allows for effective treatment which safeguards the privacy and confidentiality of interactions between you and your therapist
* From therapists who are qualified, competent, focused on your care, and reasonably accessible to you
* That emphasize your participation in developing a treatment plan specific to your needs, and include your agreement to work toward defined goals
* That in relation to intake and treatment are free of discrimination on the basis of age, sex, race, creed, color, national origin, ethnicity, religion, marital status, disability or sexual orientation

**To current information concerning:**

* How to access emergency services needed outside of normal business hours
* Resources and procedures available for communicating concerns or questions, for expressing dissatisfaction with services or care
* Possible consequences for refusing treatment plan recommendations
* Your responsibilities to ensure better treatment outcomes
* Your records, and having information explained or interpreted as a necessary, except when protected or restricted by law

Client signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_