Family Christian Counseling Center
1300 E. Missouri, Phoenix AZ 85014
(602) 325-1233
www.familycccp.org

ADULT CLIENT REGISTRATION FORM

Name: ____ DOB: ___________ Age: __________

Residential Address: __________________________________ City: ________ Zip: __________

OK to send treatment/billing information to this mailing address? ☐ Yes ☐ No

If no, please provide an alternative mailing address: _____________________________________

Home Phone: ___________________________ Messages OK? ☐ Yes ☐ No

Cell Phone: ___________________________ Messages OK? ☐ Yes ☐ No

Other phone: ___________________________ Messages OK? ☐ Yes ☐ No

Relationship Status: ☐Single ☐Married ☐Committed Relationship ☐Divorced ☐Separated ☐Widowed ☐Other

Emergency Contact: Name________________________ Relationship to you: _______________

Home phone: __________________________________ Other phone: _____________________

Primary Care Physician: __________________________Phone:__________________________

Referred by: ☐ Physician ☐riend ☐ther: ________________

I give permission to receive messages via: ☐Email ☐Text ☐Phone

I would like to receive the quarterly FCCCP Electronic Newsletter. ☐Yes ☐ No

Client Signature: _________________________________ Date:__________________________

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Office Policies and Informed Consent

Welcome to the Family Christian Counseling Center of Phoenix. This document contains important information about our professional services and business practices and will serve as a therapeutic contract.

About the Therapy Purpose and Process

It is important for you to know that therapy has both benefits and risks. Therapy often requires recalling unpleasant events and struggling with troubling issues. Consequently, people sometimes experience uncomfortable feelings such as sadness or loneliness. However, therapy has been shown to have benefits for those who undertake it. Although there are no guarantees about the outcomes of therapy, people often report significant reductions in feelings of distress, satisfactory resolution of specific problems and an improvement in relationships and overall quality of life.

Specifics about Therapy

All therapists at the Family Christian Counseling Center of Phoenix are licensed with the State of Arizona, Board of Behavioral Health Examiners, as Licensed Associate Professional Counselors, Licensed Associate Marriage and Family Therapists, Licensed Professional Counselors, or Licensed Marriage and Family Therapists. Each therapist holds a Masters Degree in Counseling with various specialties including the treatment of early complex trauma/reactive attachment disorder. The therapists are trained in and use various modalities, such as Play Therapy, Sand Tray, PCIT (Parent Child Interaction Therapy), the Neurosequential Model of Therapeutics, Filial Therapy, and EMDR (Eye Movement Desensitization Reprocessing), Theraplay and EFT (Emotionally Focused Therapy) as part of traditional “talk therapy.”

Cancellation Policy

A 24 hour notice is required for changes in appointments. Cancellations with less than 24 hours notice will incur a charge of 75% of the fee for service. No-shows and missed appointments incur a **100% of the fee for service**.

Duty to warn or protect:

Based on case law, therapists are required by law to at least warn a responsible party if a patient or client makes a threat against a given individual(s). The warning communication will be limited to those individuals who absolutely need to know and designed to provide only information necessary to protect the potential victim(s).

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Report of suspected child abuse:
Therapists serving children and adolescents are mandated by law to report any suspected physical abuse, sexual abuse, and/or neglect which appears to have been inflicted upon such minor by other accidental means or which is not explained by available medical history. The mental health provider shall immediately report such suspected abuse to a Police Officer or to Child Protective Services of the Department of Economic Security.

Payment and Fees:
- Payment is due at the beginning of each session (cash, check or credit card).
- Fees range from $110 to $155 depending on therapist.
- Some therapists chose to begin with a 75 minute intake session that will be pro-rated.
- **Sessions are 45-50 minutes (clinical hour).** Longer sessions may be pre-arranged and will be pro-rated.

Other fees:

Phone calls …………………………………………………………...**$100/ hour (pro-rated)**
Telephone consultation with other professionals at client's request………**$100/ hour (pro-rated)**
(i.e. psychiatrist, doctor, etc.)
Other services (i.e. write letters, fill out forms, **report writing**)…………..**$100/hour (pro-rated)**
Legal: attorney calls, reports, testimony preparation & court appearances... **$200/hour**
Preparation of Copies of Client Records…………………………..…….**$50.00/hour**
Returned Check Fee……………………………………………………...**$35.00**

Payment is made to the Family Christian Counseling Center of Phoenix (FCCCP).

I (name) ____ have read and understand the no show and cancelation policies of the Family Christian Counseling Center of Phoenix. In the event of default, I promise to pay my balance, together with all costs of collection.

I hereby agree to pay the fee according to (please mark one below):

_____ Intake Visit
_____ Standard Fee
_____ Group Fee
_____ No Show/Cancellation Fee (less than 24 hours)

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Therapist Availability & Emergency Procedures:

- Telephone consultations between office visits are welcome. However, we will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions.
- You may leave a message for any therapist at any time on a confidential voicemail at: (602) 325-1233. On weekends and holidays, messages are checked less frequently.
- **The office is *not* an emergency number**. In the event of a mental health crisis, please call the **24 hour EMPACT Crisis Line at 480-784-1500**. You may leave a message on our voicemail regarding the situation and we will get back to you as quickly as possible. We do not check messages after 7pm.
- **In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

CONFIDENTIALITY:

In most cases (see "Exceptions to Confidentiality" below) communications between client and therapist will be held in strict confidence - unless you provide your therapist written permission to release information about your treatment. **If you participate in couples or family therapy, the therapist will not disclose confidential information about treatment to a third party (other than to a third-party payer) unless all treatment participants (18 or older) provide written authorization to release such information.**

Exceptions to Confidentiality
Therapists are legally-mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse. Therapists are also required to break client confidentiality when it has been determined that a client presents a serious danger of physical violence to another person. A therapist may break confidentiality when she believes a client is likely to be dangerous to him or herself.

Consultation: Therapists at the Family Christian Counseling Center of Phoenix participate in supervision of their clients with their clinical supervisor, Deborah Pettitt (602-325-1233). All licensed associate counselors are required by the Arizona Board of Behavioral Health to participate in supervision. We occasionally consult with other professionals regarding our clients; however, our client's identity remains completely anonymous, and confidentiality is fully maintained.

E - Mails, Cell Phones, Computers and Faxes:
Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone communication are not guaranteed confidential methods of communication, and they are, by choice, relinquishing their rights of confidentiality.

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Maintenance of records:
All individuals receiving behavioral health services are clients of Family Christian Counseling Center of Phoenix. All records will be kept by Family Christian Counseling Center of Phoenix. According to Professional Standards your records will be kept for three (3) years after the last contact with you and either the complete record or a summary of it will be kept for nine (9) years. Records involving children will be kept for three (3) years after their 18th birthday. The content of these records should include personal data, dates of service, types of services, fees, reports, and other supporting data as may be appropriate (APA, 1993).
In the case that the Family Christian Counseling Center of Phoenix would close, patients will be informed ninety (90) days prior to such termination, and a request will be sent to the patient as to where they want their medical records sent to for the purpose of continuity of care. If it is an inactive patient, the notice will be sent to the last address on record to inform the patient as to the future location of their medical records and that the patient can access these records. If records are not claimed after the above time guidelines, the records will be destroyed. If the practice is sold, and the records do not remain in the same physical location, the patient will be informed as mentioned above and records will be transferred as per patient's request (ARS-32-3211A).
The Center will respond to requests for medical records within fourteen (14) days of such requests for active patients. If the request is for an inactive record, such requests might take longer due to the time that it might take to retrieve the records from the storage facility. Patients have the right to access their records as per State, Federal, and Professional Standards. You will need to provide the office with a written request for medical records.

Consent to Treatment:
Your signature below indicates that you have had the opportunity to read and review the information in this three page document and that questions regarding your care have been satisfactorily answered. Furthermore, it indicates your willingness to abide by its terms and that you agree to participate in treatment. A copy of this document will be provided at your request.

Client signature: ____________________________________Date_______________________

For office use only – verification that client has read the informed consent document.

Authorized Representative Signature: ______________________________Date: __________________

Client Rights

Family Christian Counseling Center shall ensure that:

A client has the following rights:

1) To be treated with dignity, respect, and consideration;
2) Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3) To receive treatment that:
   a) Supports and respects the client's individuality, choices, strengths, and abilities;
   b) Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
   c) Is provided in the least restrictive environment that meets the client's treatment needs;
4) Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
5) To submit grievances to center staff members and complaints to outside entities and other individuals without constraint or retaliation;
6) To have grievances considered by Family Christian Counseling Center in a fair, timely, and impartial manner;
7) To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
8) To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
9) To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);
10) To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without general consent, except:
    a) For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
    b) For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
    c) For video recordings used for security purposes that are maintained only on a temporary basis; or
    d) As provided in R9-20-602(A)(5);
11) To review, upon written request, the client's own record during the center's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);
12) To review client rights at the center:

13) To be informed of all fees that the client is required to pay and of the center's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;
14) To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment, and alternatives to the proposed treatment;
15) To be offered or referred for the treatment specified in the client's treatment plan;
16) To receive a referral to another professional if the center is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
17) To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;
18) To be free from:
    a) Abuse;
    b) Neglect;
    c) Exploitation;
    d) Coercion;
    e) Manipulation;
    f) Retaliation for submitting a complaint;
    g) Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs, except as established in a fee agreement signed by the client or the client's parent, guardian, custodian, or agent;
    h) Treatment that involves the denial of:
        i) Food,
        ii) ii. The opportunity to sleep, or
        iii) The opportunity to use the toilet; and
        iv) Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
19) To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
20) To control the client's own finances except as provided by A.R.S. § 36-507(5);
21) To participate or refuse to participate in research or experimental treatment;
22) To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;

23) To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility.

I have read and understand the above Client Rights

Signature:____ ____________________

Client Name **Date**

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Please Read Carefully

THIS NOTICE PROVIDES YOU WITH INFORMATION ABOUT HOW YOUR PROTECTED HEALTH INFORMATION (PHI) MAY BE USED AND DISCLOSED BY THIS PROVIDER, AS WELL AS YOUR RIGHTS REGARDING YOUR PHI. YOUR PHI INCLUDES INFORMATION WHICH RELATES TO YOUR PAST, PRESENT OR FUTURE HEALTH, TREATMENT OR PAYMENT FOR HEALTH CARE SERVICES.

1. LEGAL DUTY TO SAFEGUARD YOUR *PROTECTED HEALTH INFORMATION* (PHI).

The Health Insurance Portability and Accountability Act (HIPPA) requires me to:

- Keep your medical information private.
- Give you this notice describing my legal duties, privacy practices and your rights regarding your medical information.
- Follow the terms of the current notice.

I have the right to:

- Change my privacy practices and terms of this notice at any time, provided that the changes are permitted by law.

Notice of Change to Privacy Practices:

- Before an important change is made in my privacy practices, I will change this notice and make the new notice available upon request.

2. USE AND DISCLOSURE OF YOUR PHI

The following section describes different ways that your PHI may be used or disclosed. For some of these uses or disclosures, I will need your prior authorization; for others, I do not. I will not disclose your PHI for any purpose not listed below without your specific written authorization. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization).

Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

- ***FOR TREATMENT:*** I may disclose your PHI to other licensed health care providers who provide you with health care services or are involved in your care. For example, if you're being treated by a psychiatrist. I may disclose your PHI to your psychiatrist in order to coordinate your care.
- ***FOR PAYMENT:*** I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. I may also provide PHI to my business associates, such as my billing company, Comprehensive Billing Services, and others that process my health care claims.
- ***FOR HEALTH CARE OPERATIONS:*** I may use and disclose your PHI to operate my practice.

ADDITIONAL USES AND DISCLOSURES that do not require consent:

- ***When disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement.*** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
- ***For public health activities***. As required by law, I may disclose your PHI to public health or legal authorities charged with preventing, controlling or responding to disease, injury, disability and/or death including child abuse and neglect.

- ***For health oversight activities***. For example, I may have to report information to assist the government when it conducts an investigation or inspection of a health provider or organization.
- ***To avoid harm***. To prevent a serious threat to your own health or safety or the health or safety of others.
- ***For workers' compensation purpose***. I may provide PHI in order to comply with workers' compensation laws.
- ***Appointment reminders and health related benefits or services.*** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

3. YOUR INDIVIDUAL RIGHTS REGARDING YOUR PHI

a. ***The Right to Choose How I Send PHI to You***. You have the right to ask that I send information to you at an alternate address or by alternate means (for example, e-mail instead of regular mail). I will agree to your request so long as it is reasonable for me to do so.
b. ***The Right to See and Get Copies of Your PHI.*** In most cases you have the right to get copies of your PHI, but you must make the request in writing. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected in connection with a legal proceeding. I will respond to you within 10 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
c. **The *Right to Get a List of the Disclosures I have made***. You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to such as those named for treatment, payment, or health care operations directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or disclosures made before June 1, 2008.
d. ***The right to ask that I limit how I use and disclose your PHI***. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am " legally" required or allowed to make.
e. ***The Right to Correct or Update Your PHI.*** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct

the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 30 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (a) Correct and complete, (b) not created by me, (c) not allowed to be disclosed, and/or (d) not a part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it and tell others that need to know about the change to your PHI.

4. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES.** If you have any questions about this notice or any complaints about my privacy practices or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services please contact your provider, Family Christian Counseling Center of Phoenix. There will not be any retaliation for filing a complaint.
5. **EFFECTIVE DATE OF THIS NOTICE**. This notice went into effect on November 1st, 2010.

**** Please sign the attached consent page. You may keep these three pages for your records.****

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NOTICE OF PRIVACY PRACTICES SIGNATURE PAGE
CONSENT TO USE & DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

This form documents your consent with HIPAA laws regarding Protected Health Information (PHI) about you. This information is necessary to provide treatment, to arrange payment for services, and for business activities ("Health Care Operations").

By signing this form, you agree to allow Family Christian Counseling Center of Phoenix to use this information and share it with others for treatment-related purposes. If this Notice changes, you will be notified at our next session. You may revoke your consent at any time after signing.

I hereby acknowledge that I have reviewed and received a copy of the "Notice of Privacy Practices" for the psychotherapy practice of Family Christian Counseling Center of Phoenix.

Print Name: ______________________________ Signature: __________________________________

Print Name: ______________________________ Signature: __________________________________

Date: ____

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Permission for Animal Assisted Therapy (AAT)

____________________________________has permission to visit with the approved therapy dogs at the Family Christian Counseling Center of Phoenix (FCCCP).

- Therapy dogs at FCCCP have passed the screening of Delta Society, an internationally recognized registrar of therapy animals.
- Therapy dogs will be regularly groomed and clean when visiting with clients.
- Therapy dogs will receive regular veterinary care, and are current on their shots.
- Generally recognized safety protocols for limiting the transmission of germs via the dog will be followed.

Confidentiality - (please refer to the HIPPA notice for additional information):

- The law requires that I report suspicions or evidence of child abuse, or child's/parent's expressed intention to harm oneself or others.
- Individuals may choose to contact me via email, fax or cell phone. In doing so, they agree to the understanding that email, fax and cell phone communication are not guaranteed confidential methods of communication.

Therapist Availability/Emergencies:

- To reach any of our therapists by phone, you can leave a message on the office *cell*. This number is **(602) 325-1233.**
- If your child is having a crisis or clinical emergency, **please call 911 or the EMPACT crisis line at 480-784-1500. This crisis line is available 24 hours a day, 7 days a week.** Please leave a message for your therapist as well.
- If your child is seeing a Psychiatrist, it is advised that you contact him/her in times of emergent need.

Consent to Treatment:

- Your signature below indicates that you have had the opportunity to read the information in this document and that your questions have been satisfactorily answered.
- It also indicates that you understand and give permission for your therapist to seek clinical supervision or consultation about client issues when necessary (while maintaining client anonymity).
- A copy of this document will be provided at your request.

____Date_____________________________

Client Signature

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INTAKE QUESTIONNAIRE - Name: ____________________________

Therapist's notes

What brought you into therapy today? ______________________________
____
What do you wish to change or accomplish as a result of therapy? ___________
____
Have you been in therapy before? ☐ Yes ☐ No If yes, please state when and where: ____
____
Was it a positive experience? Yes No. What did you like or not like about it? ____
____

Reflecting on the last 6 months, please check all that apply:	
Frequently sad or depressed	Feeling restless or keyed up
Overwhelming worries	Restless unsatisfying sleep
Difficulty falling asleep or staying asleep	Muscle tension
Unable to concentrate	
Irritable and/or short temper	Mood Swings
Significant change in weight	Decreased need for sleep (only need 3-4 hrs)
Low energy level/fatigue	Feel more talkative than usual
Feeling excessive guilt or shame	Excessive spending/shopping
Unable to relax	Excessive gambling
Lack of appetite/increased appetite	Easily distracted by unimportant things
Loss of interest in activities/hobbies	Take too many risks
Feeling hopeless	
Feeling worthless	
Difficulty motivating	Troubling thoughts about the past
Withdrawn/isolating self	Nightmares
Cry easily/often	Startle easily
Difficulty making a decision	Too neat and orderly
Difficulty finishing tasks	Repeating certain behaviors over and over

Thoughts to hurt self	Easily upset or angered
Attempts to harm yourself	Feeling different from most people
Thoughts to hurt others	Shy around others
Threats to hurt others	Increasingly forgetful
	Strong fears
Feeling ill/sick	Difficulty with work or school
Stomach aches/vomiting	
Headaches/migraines	Use of sedatives

Therapist's notes

Medical History

Have you consulted a physician or psychiatrist regarding the problem which brings you here? No Yes ______________________________

Are you currently being treated for any medical problems? Yes No

Are you currently taking any medications? Yes No

List medications:

Dosage	Type	For (i.e. depression)	Prescribed by

Are you currently taking over the counter medications, herbs or supplements? Yes No ____

Are you presently in good health? Yes No ______________________

Do you engage in physical activity? Yes No If yes, what activity? ____ How often?_____________

Do you smoke cigarettes (cigars, chew)? Yes No #______per day

How much alcohol do you drink? #_______ per day _______# per week

Do you drink caffeinated beverages? Yes No If yes, how many per day?_________________

Do you use illicit drugs? Yes No - If yes, how often and what drugs do you use?____

Have you ever tried to cut down or stop using alcohol/drugs? Yes No

Has anyone ever asked you to cut down on your drinking? Yes No

Have you ever been hospitalized for any emotional/ mental health condition? □Yes□ No

Therapist's notes

Have you experienced or witnessed a traumatic event? (*Parental violence, domestic violence, community violence, natural disaster, injury or death to a loved one*, etc) □ Yes □ No
Do you have a history of domestic violence? □ Yes □ No
Do you have a history of verbal, emotional or physical abuse? □ Yes □ No
Do you have a history of sexual abuse or sexual assault? Yes No

SUPPORT SYSTEMS

Do you have one or two friends that you consider close and feel you can depend on?	□ Yes □ No	
Do have a religion or spiritual practice that you experience as supportive?	□ Yes □ No	
Do you belong to any social groups or participate in hobbies with people that you enjoy?	□ Yes □ No	
Is there a family member that you trust and can go to in times of emotional need?	□ Yes □ No	

FAMILY HISTORY

Have you or anyone in your family, experienced any of the following? If yes, please note their relationship to you. Please include extended family such as grandparents, uncles/aunts, siblings, and so on.

Have you or a family member experienced:	**Indicate Self or which Family Member (s):**
Anxiety	
Depression	
Bipolar disorder	
Learning disorders (ADHD, dyslexia, etc).	
Illicit drug use	
Alcohol abuse	

Schizophrenia	
Anger	
Eating Disorder	
Phobias	
Hospitalization for Mental Health Condition	
Attempted or completed suicide	

Therapist's notes

Please check any of the following areas that you would like to address in therapy:

Family	Career/education
Parenting	Phase of life
Children	Stress
Relationships	Assertiveness
Alcohol or Drug use	Health Problems
Verbal abuse	Childhood experiences
Physical abuse	Loss or death
Emotional abuse	Spirituality
Sexual abuse	Self-esteem
Finances	Legal issues

Is there anything else that you would like me to know? ________________________________

Therapist Signature: __________________________ Date: __________

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My Strengths are ____

My weaknesses are ____

My three (3) goals for therapy are:

1.

2.

3.

I know that I am better when:

___________________________________ Date: ___________________
Client Signature

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Discussion of Goals and Methods

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For Office Use Only – Diagnosis code ______________________________

Therapist name and credentials: ______________________________

Therapist Signature: ______________________________ Date: ____________

Client Signature: ______________________________ Date: ____________