Awareness Counseling, PC

665 W Main Street
Farmington, NM 87401 Ph (505)325-5475 fax (505)327-4554

Client Information

Please fill out completely. Thank you.

Today's Date: ____________________

Name: Last:______________________ First:_________________________ Age:______

Date of Birth:____/____/____ M__F__ Social Security #(if known)________________

Physical Address:_____________________________City:______________ State:______Zip:_____

Mailing Address: _____________________________ City: ______________State: _____Zip:_____

Home Phone:_____/_____/___ Cell Phone_____/_____/____ May we leave a message? Y__N__

Employer:______________________________ Occupation:____________________________

Did someone refer you to our clinic? __Y__N Who?_________________________________

Emergency Contact:_______________________________________ Phone:_____/_____/_____

Relationship to Client:_____________________________________

Parent(s) Name if minor_____________________________________ Phone:_____/_____/_____

____________________________________ Phone:_____/_____/_____

Insurance Information

Insurance/EAP Company:_________________________ Policy Number:_________________

Relationship to Insured: Self Spouse Mother Father Guardian

Name of Insured:__________________________________ Date of Birth:_____/_____/_____

Yearly Deductible:_____________________ Deductible Met/Co-payment Amt:___________

For Office Use Only

____ Copy of Insurance Card
____ Documents Complete
____ Verification of Insurance
____ Entered in My Clients+

Awareness Counseling, PC
665 W Main Street
Farmington, NM 87401 Ph (505)325-5475 fax (505)327-4554

Informed Consent

I consent to and authorize Awareness Counseling, PC, to administer all treatments and services that may be considered advisable in the judgment of my therapist, in accordance with their policies. If I fail to sign the consent, treatment cannot be provided.

Signature of Client (or Guardian):____

Printed Name:____

Date:______________________

Consent for Use of Healthcare Information for Purposes of Payment and Healthcare Operations

I consent to the release of, and the use by, or disclosure of my protected health information to and by Awareness Counseling, PC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations at this clinic.

I understand that Awareness Counseling, PC will bill my insurance company for services rendered. I further understand that I am responsible for payment if the claim is denied for any reason.

Signature of Client (or Guardian):____

Date:________________________

Acknowledgement of Receipt of Privacy Practice

I understand and have reviewed Awareness Counseling, PC, Notice of Privacy Practices under the Health Insurance Portability and Accountability Act (HIPAA). The Notice of Privacy Practices describes the types, uses, and disclosures of my protected health information that will occur during my treatment including the payment of my bills.

Signature of Client (or Guardian):____

Printed Name:________________________________ Date:______________

Awareness Counseling, PC
665 W Main Street
Farmington, NM 87401 Ph (505)325-5475 fax (505)327-4554

Fee Collection Procedures and No-Show Policy

In an effort to decrease unnecessary costs, contain fees, and sustain our services, Awareness Counseling, PC, has established and will maintain a **No-Show Policy.**

Please understand that our appointment times are scheduled to allow us to take care of each individual client's needs during the client's visit.

Because appointments are generally in high demand, we value advance notice from our clients who are unable to keep their scheduled appointment. We do understand that emergencies arise and exceptions will be made on an individual basis.

To promote efficient access, please read and initial next to each statement below to show that you have read, understood, and agree to each of the following:

_______ Failure to show up for a scheduled appointment will be considered a **no-show.** Insurance does not pay for no show appointments therefore a $35.00 out-of-pocket fee will be charged. This fee will need to be paid before we can reschedule you.

_______ Failure to cancel an appointment within 24 hours of my appointment will be considered a **no-show**.

_______ After a second **no-show** in a calendar year, we reserve the right to terminate the provider-patient relationship and possible discharge from the practice.

_______Should changes occur with your insurance, you will notify our office and provide a copy of the insurance card.

_______Copay payment is expected at the time of service unless other arrangements have been made.

By signing below, I acknowledge that I have read, understand, and agree to all the above statements.

Signature:___________________________________ Date:________________

Printed Name:_________________________________

Signature of Parent/Guardian if Client is under 18:_________________________________

Awareness Counseling, PC
665 W Main Street
Farmington, NM 87401 Ph (505)325-5475 fax (505)327-4554

Disclosure Statement

Required by the State of New Mexico-State Grievance Board

We are pleased you have selected Awareness Counseling, PC. This document is to inform you about our degrees and professional credentials to ensure that you understand our professional relationship.

Awareness Counseling Staff

- Your Primary Therapist is Rochelle Park, MA, LPC (CO), LPCC (NM), MAC
  BA, Fort Lewis College, Biology, 1993; BS, Fort Lewis College, Psychology 1996; MA University of Colorado, Denver, Counseling Psychology and Counselor Education 2000

- Your Primary Therapist is Deborah Karn, MA, LPC, CAC III (CO), LPCC (NM), MAC
  BS, University of Maryland, Psychology, 1995; University of Colorado, Denver, MA Counseling Psychology and Counselor Education—Marriage and Family 2000

- Your Primary Therapist is Kimberly Haynie, MSW, LMSW (NM), BSW, New Mexico Highlands University, 2015; MSW, New Mexico Highlands University, 2016.

In professional therapeutic relationship, such as ours, certain guidelines apply. Among the guidelines are:

a. You are encouraged to become knowledgeable about goals, methods and techniques.
b. You may seek a second opinion from a different therapist, or decide to stop receiving services, at any time.

EXPLANATION OF DUAL RELATIONSHIPS:

A counseling relationship is professional, not personal. You will be best served while being seen for counseling and therapy if your relationship with your therapist stays strictly professional so our sessions can concentrate exclusively on your concerns. Sexual intimacy is between a therapist and a client is never appropriate and should be reported to the State Grievance Board.

Awareness Counseling, PC

665 W Main Street
Farmington, NM 87401 Ph (505)325-5475 fax (505)327-4554

CONFIDENTIALITY

Information shared in counseling is considered privileged communication. We participate in peer supervision to ensure we are using best practice techniques. Any cases reviewed or information shared will be held strictly confidential and will occur in a confidential setting. The privacy and confidentiality of our conversations and our records is a privilege of yours and is protected by state law and professional ethics in all but a few circumstances:

a. If your clinician believes you have an intent to harm yourself and/or another person

b. If information shared suggests the possibility of child or elder abuse and/or neglect

c. If an illegal activity occurs on premises

d. If there is a medical emergency

e. If a clinician receives a legitimate subpoena

COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of our work, please inform your therapist immediately. This will make our work together more efficient and effective. If you think that you may have been treated unfairly or unethically, and cannot resolve the problem with your therapist, you can contact the appropriate state board listed.

CO Department of Regulatory Agencies
Section 1560 Broadway, Suite #1370
Denver, CO 80202 (303) 894-7766

State of NM Counseling and Therapy Practice Board.
2550 Cerrillos Road/PO Box 21501
Santa Fe, NM 87504 (505) 476-4610

______________________________	________________
Client Signature	Date
______________________________	________________
Parent/Guardian Signature	Date
______________________________	________________
Therapist Signature	Date