SONORAN LIFE SOLUTIONS, INC.
PERSONAL INFORMATION FORM

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

E-Mail address_____ Social Security#:_____

Phone (home): _____ (work) _____ (cell) _____

Where may we call you? __ Home __ Work __ Cell Leave message? __ Home __ Work __ Cell

Primary Health Insurance Plan _____ Policy Holder's Name: _____

Health Plan ID #:_____ Group ID #: _____

Policy Holder's Social Security # _____ Policy Holder's DOB:_____

Emergency contact & phone: _____

Racial Background:

__ African-American __ Asian-American __ Caucasian __ Hispanic

__ Native American __ Other _____

Religious Affiliation: _____ Currently active? _____

Education (years completed or highest degree): _____

Marital Status: __ Never Married __ Divorced __ Widowed __ Married (date: _____)

Employer: _____

Current Occupation: _____

Spouse/ Partners Name: _____

Spouse/Partners Occupation: _____

How did you hear about us?

_____

Signature: _____ Date: _____

SONORAN LIFE SOLUTIONS, INC.

FINANCIAL POLICY

Sonoran Life Solutions, Inc. accepts clients with insurance coverage as well as private pay clients. It is important that you understand that your insurance coverage is a contract between you and the insurance carrier. Sonoran Life Solutions will gladly file your insurance claims. Sonoran Life Solutions will wait a reasonable amount of time for your insurance company to pay the claim. If a claim remains unpaid by your insurance company for more than 90 days, Sonoran Life Solutions, Inc. will look to you for payment of the claim. Sonoran Life Solutions, Inc. highly recommends that you become very familiar with your insurance policy and what your benefits are under your policy. The policies can be somewhat confusing, so it may be necessary for you to call your insurance carrier directly in order to gain some clarification in regards to your benefits. In most cases, you will have a co-pay or a deductible which will be paid to our office prior to your appointments with your Therapist. When an insurance company pays Sonoran Life Solutions, Inc. we will then bill you or collect from you at your next appointment any remaining co-pay, deductible, or coinsurance that is not paid at the time of service. Billed balances are due and payable within 30 days. Sonoran Life Solutions does exercise the right to share your billing information to a collection agency if you have a balance that has been left unpaid in excess of 90 days. Payment plans for unpaid balances may be an option and would need to be discussed with our Business Manager.

Sonoran Life Solutions does have a cancellation policy which requires you to cancel your session within 24 hours prior to the session to avoid being charged. The charge for late cancellations and appointments in which there is no cancellation and no attendance is $50.00 payable to Sonoran Life Solutions, Inc. Sonoran Life Solutions, Inc. does understand at times there may be extenuating circumstances which prevent you from canceling or coming to your appointment. Sonoran Life Solutions, Inc. will consider these situations on a case by case basis. A successful outcome in therapy will be fostered by your commitment to the process.

Below are the rates for **private pay** clients and for **some services that are not covered by most insurance policies**:

Initial Intake (1hour) $120.00

Individual Therapy Session (50 minutes) $90.00

Individual Therapy Session (80 Minutes) $130.00

Family, Marriage, or Couples Therapy Session (50 minutes) $100.00

Family, Marriage, or Couples Therapy Session (80 Minutes) $140.00

Group Therapy- Prices vary depending on group. Please ask group facilitator for prices.

Telephonic Counseling (self pay per 15 minutes) $20.00 (there is no charge for brief phone conversations with your Therapist, however telephonic therapeutic sessions will be charged)

over

Photocopies of Medical Records $0.15 per page and a $50 administrative charge

Paperwork completed during a session- no charge

Paperwork outside of a regular session $20 per 15 minutes

Late Cancellation/No shows $50.00

Court Appearances (includes travel and wait time) $130 per hour

Disability related forms are provided after a minimum of four sessions with your Therapist and there will be a charge if not completed during a therapy session.

Return Check Fee $25.00

ALL PAYMENTS (INCLUDING COPAYS AND DEDUCTIBLES) ARE DUE AT THE TIME OF SERVICE.

I have read and understand this policy and will honor the guidelines of this policy

_____ _____

Signature Date

SONORAN LIFE SOLUTIONS, INC.

CONFIDENTIALITY AGREEMENT

The law protects the confidentiality of communication between clients and mental health professionals. Information can normally only be released about you to others with your written permission, though there are some exceptions you should be aware of

- When there is a suspected abuse of a child, elderly person, or disabled person

- When it is your Therapists professional opinion that you are in danger of harming yourself, another person, or are unable to care for yourself

- If you report to your Therapist that you have intentions of physically harming someone, your Therapist is required to inform that person of your intentions and notify the proper authorities.

- When the information is required by your insurance carrier in order for Sonoran Life Solutions, Inc. to be reimbursed for services provided or for quality management services.

-Your Therapist may disclose your information to other Sonoran Life Solutions, Inc. licensed Therapists for the purpose of supervision, consultation, or to coordinate services if you or your family members are seeing different Therapists in the office.

Appropriate assessment and treatment records are required to be kept by law and professional standards. Due to these being professional records, and sometimes written in technical jargon, it is possible for them to be misinterpreted by someone who is not familiar with mental health records. You do have the right to view your records, however it is not our practice for clients to review them directly without professional interpretation.

I have read and agree to the above terms:

Client Name (Print) _____

Client Signature _____Date_____

Witness Signature_____ Date_____

SONORAN LIFE SOLUTIONS, INC.

INFORMED CONSENT

I, the undersigned, voluntarily consent to participate in psychotherapeutic services provided by Sonoran Life Solutions, Inc. I understand that I may withdraw from therapy services at any time. I understand that I have the right to have any complaints heard and resolved in a timely manner. If you have a complaint about your treatment, therapist, or any office policy, please inform us immediately so we can resolve the issue. We look forward to providing the best services possible to you and we value you as an individual with choices. With that said, we are pleased you have chosen Sonoran Life Solutions, Inc. to assist you in your journey to happiness.

_____

Name (please print)

_____

Signature of client or legal guardian Date

_____

Therapist signature Date

ADULT HISTORY:

Family members

Name	Age:	Relationship: (Spouse, Son, Daughter)	Living with you (Y/N)
1			
2			
3			
4			
5			
6			

No. of previous marriages:_____

LIST/DESCRIBE WHAT CHANGES YOU WANT TO MAKE WHILE IN COUNSELING:

_____

_____

_____

_____

_____

What causes the problem(s)? _____

_____

When did it start?_____

_____

FAMILY HISTORY:

	Yes	No	Relationship: Mother	Father	Brother	Sister	Grand parent
Drugs/ Alcohol:	☐	☐	☐	☐	☐	☐	☐
ADHD:	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐

Other (Diabetes, Thyroid, Tourette's, Seizures, Hypertension) _____

_____

_____

_____

MEDICAL HISTORY

Are you currently under the care of a physician? _____ Yes _____ No Reason? _____

When was your last checkup? _____

Please list any prescription or over the counter medications you are currently taking: _____

_____

_____

_____

Doctor's name _____ Phone number: _____

Current medical issues _____

_____

Past medical issue; include hospital stays, head injuries, etc., and dates it happened:_____

_____

_____

TREATMENT HISTORY:

Have you ever received counseling for any reason? (If yes, please list when and why) _____

_____

Have you ever been hospitalized for a psychiatric reason? (If yes, please list when and why) _____

_____

Have you ever received treatment for drugs or alcohol? (If yes, please list when and why)_____

_____

Have you ever attended any self- help groups such as AA, CODA, etc.?_____

_____

WEIGHT: □ Unchanged □ Weight gained (Last 6 mo) _____ □ Wt. Loss (6 mo) _____

□ Purging (Freq) _____/_____ □ Binging

(Freq) _____/_____ □ Laxative Use □ Diuretic use □ Diet Pills □Menstrual

Problems (Explain) _____

_____

_____

SLEEP: □ Unchanged □ Can't fall asleep □ Sleep constantly □ Awaken early □ Nightmares

□ Can't wake up □ I sleep but I don't feel rested

COMMENTS: _____

_____

_____

SUBSTANCE /ALCOHOL USE

Do you or have you ever had a substance abuse problem? □ No □ Yes □ Now □ In the past

Have other people thought you might have a substance abuse problem? □ No □ Yes □ Not currently

Do you believe someone in your family might have a substance abuse problem? □ No □ Yes Who? _____

Method/ Frequency/ Date of last use/ Type of drug: □ IV □ Snorted □ Swallowed □ Smoked

Do you use tobacco? □ No □ Yes If so, how much daily?_____

Alcohol Use:

Frequency: _____ Usual drinks/ sitting _____ Intoxication: _____

ALCOHOL RELATED EXPERIENCES IN THE LAST SIX MONTHS

□ Binges □ Job problems □ Sleep disturbance □ Physical withdrawal

□ Hangovers □ Arrests □ Blackouts □ Medical complications

□ Assaults □ Passed out □ Seizures □ Concern over driving

□ DUI □ Interpersonal problem □ Inability to stop after the 1st drink

Other Substance use (in the last six months)

Substance: _____ Freq. _____ Amount _____ Duration _____

Substance: _____ Freq. _____ Amount _____ Duration _____

SUICIDAL THOUGHTS: □ Yes, current □ Yes, in the past □ No

SUICIDAL PLAN OR INTENT: □ Yes, current □ Yes, In the past □ No

If you feel like hurting yourself now, do you have a plan? (If so, please explain)

Past attempts: □No □ Yes # of attempts _____ □ Self- mutilation _____

Date of last attempt: _____ Method: _____

HOMICIDAL THOUGHTS: □ Yes □ Yes, In the past □ No

HOMICIDAL PLAN OR INTENT: □ Yes, current □ Yes, In the past □ No

If you feel like hurting someone now, do you have a plan? (If so, please explain)

Have you ever been violent or hurt someone? □No □ Yes (If so, please explain using dates)

Is there anything else you think we should know in order to be helpful?

SONORAN LIFE SOLUTIONS, INC.
13460 N. 94th Drive K-3
Peoria, Arizona 85381
(623) 974-3333

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

This authorizes Sonoran Life Solutions, Inc. to disclose information concerning

me, _____

to _____

The purpose of this disclosure is related to my therapeutic work including:

_____ diagnostic impressions
_____ recommendations
_____ treatment process & response to treatment
_____ psychosocial history
_____ progress
_____ telephone consultation
_____ other (specify) _____
_____

I understand I may revoke my consent to allow release of information at any time, except to the extent that action will have been taken on information released prior to the revocation of my consent. This consent form is valid until _____.

Signature _____ Date _____

Witness _____

Any re-disclosure of record information by recipient is prohibited by Federal Law.