

Information Susan Warren will need if you are using insurance and Informed Consent:

**Before your appointment I will need you to give me the following information so your insurance benefits can be verified:**

1. The name of your insurance company?
2. The company for your mental/behavioral health benefits? It may be different.
3. Whether or not I'm a provider for your particular mental/behavioral plan?
4. If not, will they pay me as an out of network provider?
5. The ID number of the patient and the insurance holder?
6. The Group number?
7. The insured policy holder's name (you, a parent, a spouse), their DOB, address, telephone number, social security number, and where they work?
8. The patient's name, DOB, address, telephone number, work/school, /full/part time, marital status?
9. The phone number on the back of your card for mental/behavioral health, the mailing address, and the customer service number?
10. Your annual deductible and what amount is still due for this year?
11. How many visits you are allowed in a year?
12. How many visits you have left for the year?
13. When your year begins and ends?
14. What the co-pay is for the initial visit and after the initial visit?
15. Do you need an authorization number?

While I may be a provider for your insurance company that does not guarantee that I am a provider for a smaller company they may be using for mental/behavioral issues. I will only provide the services your insurance allows. Please be aware this is a fragrance free office and that aside from your initial appointment **I do not call to remind you of your appointments with me.** You will be responsible for that but I will give you appointment cards with your appointments listed. I'm attaching the forms along with the directions on the last page so please read everything. You will need to **print out all the forms first then fill them out and sign the bottom of each page. You will need to bring all the forms, information, and your insurance card for your first session or I will not be able to see you.** If you do forget them there will be a clipboard in the waiting area with forms to fill out there too. Please be aware that if you communicate with me through the Internet you do so at your own risk. If insurance is not being used I charge \$150 for the initial consult and \$120 for following sessions unless we've made prior arrangements. Payment is due at the time of service. I accept cash or checks. You may also pay through PayPal using my email [susankwarren@comcast.net](mailto:susankwarren@comcast.net). **Please give me 24 hours cancellation preferably by calling 520-742-1780 or email me to cancel. I will charge you for the full amount/insurance amount if not cancelled within 24 hours time, except in true emergencies.**

The insurance information I've given is valid, up to date, and I understand I am responsible for payment if my insurance does not reimburse Susan Warren.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Susan Warren, MA, LPC, LISAC  
6510 N. Camino Libby, Tucson, AZ 85718 (520) 742-1780

CLIENT RECORD/INFORMED CONSENT

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Email \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Relationship Status \_\_\_\_\_ Age \_\_\_\_\_

Spouse/Partner/Children's names \_\_\_\_\_ Age \_\_\_\_\_ Living arrangements \_\_\_\_\_

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

Referred \_\_\_\_\_ Physician \_\_\_\_\_ Tel# \_\_\_\_\_

Housing: Own home \_\_\_ Rent \_\_\_ Alone \_\_\_ Family members/Roomate(s) \_\_\_\_\_

\_\_\_\_\_

Pets \_\_\_\_\_ Support/Friends \_\_\_\_\_ Tel# \_\_\_\_\_

Financial source of income/assets \_\_\_\_\_ Education \_\_\_\_\_ Work \_\_\_\_\_ How long? \_\_\_\_\_

Other Work Experience/how long? \_\_\_\_\_ Military \_\_\_\_\_

Health condition \_\_\_\_\_ Past/Present Illness \_\_\_\_\_

Surgeries \_\_\_\_\_ Accidents \_\_\_\_\_

Mental Health Diagnosis \_\_\_\_\_ Medications \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Tel# \_\_\_\_\_ Past Medications \_\_\_\_\_

Health Insurance \_\_\_\_\_ Insured (Spouse/parent/partner/self) \_\_\_\_\_ Insured's DOB \_\_\_\_\_

Insured's  
SS# \_\_\_\_\_ Employer/Address \_\_\_\_\_ Tel# \_\_\_\_\_

Insured's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_ Address \_\_\_\_\_ Tel# \_\_\_\_\_

Date Symptoms began \_\_\_\_\_ Traumas \_\_\_\_\_

Estimate the amount of alcohol, tobacco, caffeine, sugar you consume daily, when each was used last?

\_\_\_\_\_

Exercise \_\_\_\_\_ How often \_\_\_\_\_

Do you have an alcohol/drug problem \_\_\_\_\_ Dependency \_\_\_\_\_ Blackouts \_\_\_\_\_

Drug(s) of choice \_\_\_\_\_

Have you ever overdosed? \_\_\_\_\_ Hospitalized? \_\_\_\_\_ When? \_\_\_\_\_

Describe your mood lately \_\_\_\_\_ Does It change often? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever thought of harming or killing yourself? \_\_\_\_\_ Have you? \_\_\_\_\_ When? \_\_\_\_\_ Last time? \_\_\_\_\_

Are you presently involved in legal action of any kind? \_\_\_\_\_ Agency Involvement \_\_\_\_\_

What do you consider to be your ethnic/cultural heritage or background? \_\_\_\_\_

Do you have religious or spiritual beliefs or practices? \_\_\_\_\_

List any 12 Step involvement \_\_\_\_\_

Previous therapy? \_\_\_\_\_ With whom? \_\_\_\_\_ When? \_\_\_\_\_

Do you have issues with any of the following:

Nervousness \_\_\_ Depression \_\_\_ Anxiety \_\_\_ Fears \_\_\_ Phobias \_\_\_ Anger \_\_\_ Loneliness \_\_\_ Mood Swings \_\_\_

Self-control \_\_\_ Impulse Control \_\_\_ Stress \_\_\_ Tiredness \_\_\_ Concentration \_\_\_ Memory \_\_\_ Decision making \_\_\_

Insomnia \_\_\_ Sexual problems \_\_\_ Headaches \_\_\_ Relationship issues \_\_\_ Abuse \_\_\_ Food \_\_\_ Body issues \_\_\_

What brings you in to counseling therapy at this time? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your goals in counseling? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How will you know when you've attained them? \_\_\_\_\_

I agree that by my signature, I give Susan Warren permission to bill my insurance company. I understand that I am responsible for all charges should my insurance company refuse payment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## **General Consent to Treatment and Informed Consent**

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By signing this form, I voluntarily consent to counseling for relevant treatment issues. I understand this process requires effort on my part, it may require me to face difficult issues and/or changes, and may involve risk of discomfort or no experience of change. Treatment procedures may include discussion and exploration of emotional issues, behavioral patterns, family and relational patterns, and other appropriate procedures such as Cognitive/Behavioral Therapy, EMDR, Thought Field Therapy, Clinical Hypnotherapy, and NLP. I understand I have the right to participate in the formulation of my treatment plan as well as periodic revisions and reviews. If I require information about my treatment records, I have the right to obtain copies of my records or a treatment summary. I understand I can terminate this counseling relationship at any time and can accept or decline any recommended treatment. I may withdraw this consent to treatment and will then be advised of the consequences of such withdrawal. I also understand that the therapist may terminate the professional relationship when therapeutically necessary, and other treatment options will be discussed at that time.

Current research substantiates that memories may not always be factually accurate. The meaning that one gives to their memory of events is what is important. As I process my experiences in therapy, I can release binding, traumatic emotions and discover healthy ways to be with the past in the present.

I understand that information discussed during sessions is confidential and cannot be disclosed without my consent unless:

1. It is determined I am a danger to myself or to others.
2. I give my consent in writing.
3. Information is disclosed regarding child or elder abuse/neglect.
4. Disclosure is court ordered.
5. My services were obtained to enable/aid anyone to commit or plan to commit a crime.

I understand that Susan Warren, MA, LPC participates in case consultation and may discuss aspects of my counseling work in her consultation group, and will keep identifying information about me and my counseling work confidential. I understand that Susan Warren cannot guarantee 100% confidentiality in phone conversations, email, Skype, IChat, or other electronic means.

We will formulate a treatment plan, review it every 6months/1 year and make any necessary adjustments as we progress. When we terminate treatment we will establish a discharge date and formulate an after care plan. You have a right to refuse treatment, to withdraw informed consent for treatment in writing and Susan will inform you of any possible consequences.

Client confidentiality will be completely respected by Susan with the exception of child/adolescent/adult abuse/neglect and homicidal/suicidal ideation and any other situations the law requires to be reported. Clients will be expected to maintain the confidentiality of anyone seen or met at the counseling office. Insurance billing will be done through Betty Thomson, 520-906-0184 using an on line billing company called Office Ally. Your records will be kept for 7 years from the date of your last consultation and then will be shredded or burned.

In case of Susan's demise/retirement they will be stored/maintained through 1) Wendy Guffey MA (928) 245-6101 or 2) Anne Russell EdD (520) 954-5085 for the remaining years.

If Susan is incapacitated she refers you to Lynn Namka, EdD, (520) 825-4766 to continue your therapy. If you would like your records please send Susan a signed dated letter stating that you are requesting them to be released to you. Please keep a copy of this for your records.

For **private pay** clients the 45-50 minute initial consultation (office/telephone) fee is \$150, following sessions are \$120 for individual, couples, family sessions, and for written reports, letters and phone calls more than 5 minutes long will be prorated at that rate. Please pay your fee (cash/checks/Pay pal) at the beginning of the session. If there is a financial need, a sliding fee rate will be negotiated based on total family income, assets, or ability to pay. **All Insurance clients** will be responsible for meeting their deductibles, co-pays, and they will be held responsible for payment if their insurance does not reimburse me. Appointment will be made on my business cards and you will only be called as a reminder for your initial appointment and will be responsible for remembering all appointments scheduled in advance. **All Clients will be responsible for canceling their appointments 24 hours in advance by telephone, rather than email, or they will be charged for the full fee and any collection fees through General Business Recoveries, INC, a collection agency. Insurance does not pay if you miss an appointment so you will be responsible for the full amount but if there is a true emergency the fee can be negotiated. There will be a \$20.00 charge on all returned checks. My signature below indicates that I understand and will honor this policy.**

Signed \_\_\_\_\_ Dated \_\_\_\_\_

Thank-you

Susan Warren M.A. LPC LISAC CHT  
MA, Licensed/Certified: Professional Counselor (LPC-1182), Substance Abuse  
Counselor (LISAC-0717)  
6510 N. Camino Libby, Tucson AZ 85718 (520) 742-1780  
[susankwarren@comcast.net](mailto:susankwarren@comcast.net)

**Susan Warren, MA, LPC, LISAC**  
**(State Licensed Professional Counselor, Substance Abuse Counselor)**  
**6510 N. Camino Libby, Tucson, AZ 85718 (520) 742-1780**

**Abbreviated Notice of Privacy Practices (NPP)/Informed Consent**

**My commitment to your privacy:**

My practice is dedicated to maintaining the privacy of your personal health information and I am required by law to do this. Please ask me any questions. I will use the information about your health that I get from you or from others mainly to provide you with treatment, to arrange payment for my services, or for some other business activities that are stated in the law as health care operations. You will need to read and sign the Consent Form so that I can treat you. If you want to disclose your information for any other purposes I will discuss the Consent for Release of Information Form with you.

The law may require that I share your information in the following situations:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.
2. I am required by law to report child abuse and elder abuse.
3. I may be required to report some types of lawsuits or legal proceedings.
4. If a law enforcement official requires that I do so.
5. For Workers Compensation and similar benefit programs.
6. Other situations like these are described in the longer version of the Information and Portability and Accountability Act.

Your rights regarding your information:

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home and not to call you at work to schedule or cancel an appointment.
2. You have the right to ask me to limit what I tell certain individuals involved in your request. If I do agree, I will keep my agreement except if it is against the law, an emergency, or if the information is necessary to treat you.
3. You have the right to look at the health information I have about you, such as your medical and billing records. You can even get a copy of these records, but I have the right to charge you for that service. Contact me, as Privacy Officer, to arrange to see your records.
4. If you believe the information in your records is incorrect or incomplete, you can ask me to make some kinds of changes (called amending) to your health information. You must make this request in writing and provide the request to me, as Privacy Officer. You must tell me the reasons you want to make any change(s).
5. You have a right to a copy of this notice. If I change this NPP, I will post the changed document in the waiting room. You may always receive a copy of this NPP from me.

You have the right to file a complaint if you believe your privacy right have been violated. You can file a complaint with me and with the Secretary of the Department of Health and Human Services in Washington, DC, Office of Civil Rights. 200 Independence Ave. S.W. Washington, D.C. 20201 (877) 696-6775 (toll free). All complaints must be in writing. Filing a complaint will not change the health care I provide you in any way. If you have any questions regarding this notice or my health information privacy policies, please contact me as Privacy Officer by phone at (520) 742-1780.

Susan Warren, MA, LPC 1182, LISAC 0717

Sign \_\_\_\_\_ Date \_\_\_\_\_

Susan Warren, MA, LPC, LISAC  
(State Licensed Professional Counselor, Substance Abuse Counselor)  
6510 N. Camino Libby, Tucson, AZ 85718 (520) 742-1780

**Consent to Use and Disclose Your Health Information/Informed Consent**

This form is an agreement between \_\_\_\_\_ and Susan Warren, MA, LPC (Licensed Professional Counselor), allowing consent to use and disclose your health information. When the word “you” is used, it will also refer to your child, relative, or other person, if you have written his/her name here and are acting as his/her guardian.

When I examine, diagnose, or treat you I will be collecting what the law calls Protected Health Information (PHI) about you. I will use this information to decide what treatment is best for you and to provide this treatment for you. I may also share this information with others who provide treatment to you or use it to arrange payment for your treatment, or for other business or government functions.

By signing this form you are agreeing to let me use your information here and to send it to others. When required by law or your insurance company. The Notice of Privacy Practices (NPP) explains in more detail your rights, and how I may use and share your information. Please read this before you sign this Consent Form.

If you do not sign this Consent Form acknowledging that I have provided you with a copy of my Notice of Privacy Practices, I cannot treat you.

In the future I may change how I use and share your information, and so may change my Notice of Privacy Practices (NPP). If I do change the NPP, you may ask for a copy from me, as the Privacy Officer. Please feel free to call me at my office (520) 742-1780.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wishes unless compelled by law or other regulations.

After you have signed this Consent, you have the right to revoke this Consent. You must provide all revocation requests in writing, detailing your wish to revoke your consent. I will comply with your written request about using or not using your information from that time on. However, I may have already used or shared some of your information, and I will not be able to retrieve or change the already released information.

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Signature of Client or Personal Representative

Date

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Printed Name of Client or Personal Representative

Relationship to Client \_\_\_\_\_

Susan Warren, MA, LPC, LISAC  
6510 N. Camino Libby  
Tucson, Az. 85718  
(520) 742-1780

FINANCIAL AGREEMENT/INFORMED CONSENT

I understand and agree, whether signing as an agent or as a patient and whether insured or a member of a health maintenance organization, or am self-pay, that in consideration of the services to be rendered, that I hereby individually obligate myself to pay the account of the medical facility in accordance with the regular rates, terms and interest on the unpaid balance set out by the facility. I understand that I will be responsible for eighteen percent (18%) per annum interest on the unpaid balance if my account becomes delinquent. In the event that it is necessary to place the account with a collection agency to collect the balance due, an additional fifty percent (50%) of the principle balance due will be added to help defray the cost of collection. In addition, should legal action become necessary to collect the balance due, I understand that I will be responsible for reasonable attorney's fees, interest and court costs. I also understand that if my account is placed with an agency for collection or placed with an attorney for legal action that a credit report will be pulled for the sole purpose of collecting the delinquent account.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Agent Name  
Relationship to Patient \_\_\_\_\_

\_\_\_\_\_  
Patient's Agent Signature

\_\_\_\_\_  
Date

## **Susan Warren, MA, LPC, LISAC, CHT**

**Directions to 6510 N. Camino Libby, a home office**

**(520) 742-1780**

**On Orange Grove E of 1<sup>st</sup> Ave and W of Skyline/Ina/Sunrise there will be a yellow cross road sign for Camino Arturo. Turn N towards the Catalina Mountains on Camino Arturo. Camino Libby is the first L turn. 6510 Camino Libby is the 3<sup>rd</sup> house on the R. When you turn to come up the driveway by the mailbox take the first right as that is a circular driveway and the easiest way to come and go. Please pull far enough forward so the next person has room to park behind you even though there is usually a 10-15 minute gap between people's appointments. The carport door is the entrance to my office and there will be forms on the bench for you to fill out if you haven't yet. I will come out for you at your appointment time. You are welcome to ring the bell but I may still be with someone or on the phone but will respond as soon as possible. If I'm in session you won't be able to reach me by phone but sessions are 45-50 minutes long so they are usually over at 10-15 minutes to the hour so you could reach me then if you need further directions. As I am a one-person office I am not able to call to remind you of your appointment so please be responsible for your appointment time that I will write on an appointment card. Please call 520-742-1780 to give me 24 hours notice to cancel an appointment to avoid being charged in full for the session. Insurance does not cover missed appointments. I prefer you do not use email to cancel appointments as email is not reliable, I don't text, or receive emails through my phone. Please bring cash or checks as I do not accept credit cards, or arrange payment beforehand through PayPal. Please be aware this is a fragrance free environment. You may knock to let me know you've arrived but I may not be able to respond until I've completed the session or phone call.**

**Thank-you and I look forward to meeting you.**

**Susan**