Patient Name: _____ Appointment Date: _____

DV Services - Fee Schedule

DV Screening and Assessment - $250

DV Classes -$40 per session

(26,36 or 56 based on assessment and AZ statutes)

All services are completed in person. Classes are completed in a group setting.

Before you are *scheduled* you must provide:

- ❑ Copy of current protective orders if applicable
- ❑ Court order
- ❑ Fees Paid
- ❑ Completed Packet
- ❑ Photo ID
- ❑ Must Notify us of any orders of protection in place

All fees must be paid at the time of service.

Signature_____Date_____

Group Counseling Guidelines

What's said in the group stays in the group.

Confidentiality is the shared responsibility of all group members and leaders.

Regular attendance is expected

Members agree to come on time to every session. If you are late, you will not be allowed to attend.

If more than 3 classes are missed, participants may be discharged from class and will have to restart the series over.

Missing a group session without prior notice or approval will result in a no-show fee equal to the cost of that session.

Safety of group members is important

If you experience thoughts of self-harm, suicide, or harm to others, make separate contact with the counselor to discuss your thoughts. If you are in crisis, you commit to seeking out the help that is required to keep you and others safe. Possible actions include going to the emergency room, calling 911 or 988

Signature_____Date_____

Patient Responsibility/HIPAA

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Arizona Recovery Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signature_____Date_____

Patient Name_____DOB_____

Patient Name: _____ D.O.B: _____Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers (home) (_____)_____(cell) (_____)_____

Email Address _____

Male or Female _____

Emergency Contact(s) Information: How did you hear about Arizona Recovery Center? _____

Name	Relationship to you	Phone Number

Court required assessments, education and / or therapies are NOT covered by your Health Insurance Company per State Law.

Social and Occupational History

Current Marital Status (circle one): single separated divorced widowed married domestic partner

Do you have any children? YES NO Do they live with you? YES NO

Are you currently employed outside the household? YES NO

If yes, occupation? _____

If not employed, how long have you been out of work? _____

Patient Name: _____ DOB: _____

Past Mental Health History

Have you ever had outpatient treatment by a psychiatrist or therapist? Yes / No If yes, when and by whom?

_____

_____

Have you ever received counseling or psychotherapy in the past? Yes / No If yes, when and by whom?

_____

_____

Have you ever been hospitalized for psychiatric reasons? Yes / No If yes, when and where?

_____

_____

Have you ever received substance abuse treatment? If so, what were the dates and locations?_____

_____

_____

Do you have any Current or PAST Orders of Protection or no- Contact Orders issued by a court? If yes, please list.

_____

_____

List your history of Domestic Violence , even if it did not result in your arrest

_____

_____

Patient Name: _____ DOB: _____

Please review & initial all items:

_____ **1.** I must call 24 hours prior to an appointment to cancel or reschedule my appointment. If I do not provide the notice, my account will incur a no-show fee and this must be paid at the following visit, prior to the scheduled time or to receive any refills on prescriptions.

_____ **2.** I will submit my own urine specimen for drug screen upon my provider's request at assessment. All Urine Drug Screens may be subject to a $50 office fee.

____ 3**.** I understand that rude or disrespectful treatment of the staff of Arizona Recovery Center is not tolerated and may result in my discharge. (Ex: using profanity, raising my voice, making vulgar or inappropriate comments)

Notification of Supervision

I understand that the assessment/counseling services may be provided by a Behavioral Health Technician who will be under the supervision of Kristen Long, MS, LPC, MAC. During the period of supervision, Kristen Long, MS, LPC, MAC will have unrestricted access to my entire file. This authorization is given with my understanding that by law, the clinician must report any disclosed or suspected child or elder abuse or any serious threat to safety of self or others.

Kristen Long, MS, LPC, MAC can be reached at Arizona Recovery Center, 84 Acoma Blvd. N Ste 104 Lake Havasu City, Arizona. 928-733-5101

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO PARTICIPATE IN ASSESSMENT, DIAGNOSIS AND TREATMENT WITH ARIZONA RECOVERY CENTER.

Patient Signature: _____ Date: _____

I, _____hereby authorize **Arizona Recovery Center** to release and receive confidential health information concerning my physical health, mental health and/or substance use disorders to the parties listed below.

Lake Havasu City Municipal Court
2001 College Drive #148
Lake Havasu City, AZ 86403
Fax: 928-680-0193
Phone: 928-453-0748
Email:LakeHavasuMunicipalCourt@courts.az.gov

Lake Havasu City Justice Court
2001 College Drive #148
Lake Havasu City, AZ 86403
Fax: 928-453-0711
Phone: 928-453-0705
Email:LakeHavasuJusticeCourt@courts.az.gov

Mohave County Probation Department
2001 College Drive #129
Lake Havasu City, AZ 86403
Fax: 928-
Phone: 928-453-0707

Minimum information to be released:

- Dates of Service
- Treatment Plans
- Progress Reports
- Compliance to the Program

Arizona Recovery Center

Emily Vona, FNP-C and Kristen L. Long LPC, MAC

84 Acoma Blvd. North Suite 104 Lake Havasu City, Arizona 86403

Phone: 928-733-5101 Fax: 610-273-5590

Email: info@azrecover.com

Signature_____Date_____

Patient Name_____DOB_____

Address_____

City, State, Zip_____