Dragonfly International Therapy, LLC
3231 S. Country Club Way, Suite 111, Tempe, AZ 85282
11031 E. Victoria St., Chandler, AZ 85248
(Main) 480.370.7630
www.dragonflyinternationaltherapy.com

**CLIENT INFORMATION**

***Please sign and complete in black pen only***

Today's Date:_________________________

Name of Client:_____________________________________________________________________

Date of Birth: _____________________ Age:_________ Sex: ☐ Female ☐ Male

Address:____________________________________City__________________ ZIP _____________

Receive newsletter via email? ☐ Yes ☐ No If Yes, Email Address: ___________________________

Home Phone #: ___________________________ Messages OK? ☐ Yes ☐ No

Cell Phone # _______________________ Messages OK? ☐ Yes ☐ No

Alternative Phone#: _______________________ Messages OK? ☐ Yes ☐ No

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

If no, please provide an alternative mailing address:

Address:____________________________________City__________________ ZIP _____________

By whom were you referred?___________________________________________________________

Marital Status: Single Married Committed Relationship Divorced Separated Widowed Other

**Emergency Contact**

Name:______________________________________Relationship:_________________________

Phone #'s: Home______________________________ Alternative __________________________

Client's Legal Guardian:_____________________________ Relationship to Client: ____________

**Reflecting on the last 6 months, check all that apply**

| | | | |
|---|---|---|---|
| Frequently sad or depressed | | Flashbacks | |
| Frequently anxious | | Financial difficulties/ excessive debt | |
| Mood swings | | Excessive anger or rage | |
| Easily upset or angered | | Excessive conflict | |
| Withdrawn or isolative | | Repeat certain behaviors over and over again | |
| Strong fears | | Increasingly forgetful | |
| Cry easily/often | | Difficulty finishing tasks | |
| Change in sleep pattern | | Insomnia | |
| Change in appetite | | Nightmares | |
| No interest in hobbies | | Difficulty with work or school | |
| Feeling hopeless | | Excessive sweating | |
| Shy with people | | Headaches/migraines | |
| Difficulty making a decision | | Dizziness | |
| Fatigue | | Fainting spells | |
| Trouble concentrating | | Stomach aches | |
| Feeling lonely | | Use of alcohol | |
| Feeling different from most people/ inferior | | Feeling ill/ sick | |
| Change in sexual behavior/libido | | Thoughts of hurting others | |
| Difficulty concentrating | | Thoughts of hurting self | |
| Difficulty motivating | | Use of Sedatives | |
| Too neat and orderly | | Use of pain killers and analgesics | |
| Overwhelming worries | | Other: | |
| Unable to relax | | Other: | |
| Frequent isolation | | Other: | |

Have you ever been in counseling before? ☐Yes ☐No
If yes, when? ____________________ For what?__________________________________________
What brought you into counseling today? _______________________________________________
_________________________________________________________________________________
Do you have any current or past medical problems? ☐Yes ☐No
If yes, please explain ___________________________________________________________________
Have you ever had or currently have seizures? ☐Yes ☐No
Are you currently taking psychotropic medication? ☐Yes ☐No
If yes, who is prescribing them for you? ___________________________________________________
List medications: Type Dosage

____________________________________________________________
____________________________________________________________

Are you a United States Veteran? ☐Yes ☐No If Yes, have you been in combat? ☐Yes ☐No
Do you drink caffeinated beverages? ☐Yes ☐No #_________per day
Do you smoke cigarettes? ☐Yes ☐No #_________per day
How much alcohol do you drink? #_________per day # per week _________
Do you use illicit drugs? ☐Yes ☐No
If yes, how often and what drugs do you use_______________________________________________
Have you a history of trying to stop using alcohol or drugs? ☐Yes ☐No
If yes, please explain ___________________________________________________________________
If you have any other concerns please state: ____________________________________________

***While you were growing up, during your first 18 years of life:***

1. Did a parent or other adult in the household often or very often…Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? ☐Yes ☐No

2. Did a parent or other adult in the household often or very often…Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? ☐Yes ☐No

3. Did an adult person at least 5 years older than you ever…Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? ☐Yes ☐No

4. Did you often or very often feel that …No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? ☐Yes ☐No

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ☐Yes ☐No

6. Were your parents ever separated or divorced? ☐Yes ☐No

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife? ☐Yes ☐No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? ☐Yes ☐No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? ☐Yes ☐No

10. Did a household member go to prison? ☐Yes ☐No

Dragonfly International Therapy
3231 S. Country Club Way, Suite 111, Tempe, AZ 85282
11031 E. Victoria St., Chandler, AZ 85248
(Main) 480.370.7630
www.dragonflyinternationaltherapy.com

## OUTPATIENT COUNSELING SERVICES CONTRACT

This document contains important information about the professional services and business practices of Dragonfly International Therapy. Please read it carefully and jot down any questions you might have so that they can be discussed. Therapy is different from visiting a medical doctor in that it requires a very active effort on your part. In order to be most successful, you will need to work both during your sessions and at home. Therapy has benefits and risks. Risks sometimes include experiencing uncomfortable feelings like sadness, loneliness, or recalling aspects of your personal history that you find unpleasant. Still therapy has been shown to have significant benefits for people who undertake it. Therapy often promotes a significant reduction in feelings of distress while improving relationships and the quality of life by resolving specific problems. Still there are no absolute guarantees with regard to what will happen. By the end of our assessment period, your therapist will be able to share with you what your time together will include. If you decide to continue, you should evaluate this along with your assessment of whether your therapist is a person with whom you feel comfortable working. Therapy involves a commitment of time, money and energy, so you should be very careful about the therapist you select. If you have any questions about your therapy experience, please discuss them whenever they arise. If doubt persists, your therapist will be happy to help you secure an appropriate consultation with another behavioral health professional.

## SPECIFICS ABOUT DRAGONFLY INTERNATIONAL THERAPY

Sarah Jenkins MC, LPC, CPsychol is licensed and registered with the State of Arizona Board of Behavioral Health Examiners to practice independently as a Licensed Professional Counselor with a Masters degree from The University of Phoenix and is also registered as a Chartered Psychologist with the British Psychological Society. Sarah also specializes in EMDR Therapy (Eye Movement Desensitization Reprocessing) and is an EMDRIA Approved EMDR Training Provider, EMDRIA Approved EMDR Consultant and Certified EMDR therapist. Sarah also provides Equine-Assisted EMDR and Equine-Assisted Therapy services. Please note that current research is limited to the application of EMDR to trauma related disorders. Bryon Sabatino LPC, LISAC is licensed and registered with the State of Arizona Board of Behavioral Health Examiners to practice independently as a Licensed Professional Counselor and Licensed Independent Substance Abuse Counselor with a Master's Degree from Arizona State University.

If you should have questions or concerns about the way that your treatment is preceding, please bring your concerns up directly with your therapist. If, after informing your therapist you are still dissatisfied or have concerns about Dragonfly International Therapy or our methods, you may make any complaints or concerns with the State of Arizona Board of Behavioral Health Examiners, 1400 West Washington Street, Suite 235, Phoenix, Arizona 85007 602.542.8162

## PROTECTED HEALTH INFORMATION

Privacy is a very important concern for all who come to this office for help. Due to the complicated nature of federal and state laws regarding your protected personal health information, a "Notice of Privacy Practices (NOPP)" has been created. It is suggested that you review a copy of the "NOPP" and ask questions about anything contained in this document. You may also request a personal copy of this notice at any time.

## EMERGENCIES

To reach your therapist by phone, you can leave a voice mail message. **Sarah Jenkins 480.370.7630 Bryon Sabatino 480.221.1013** *Please also note that your therapist will not communicate with you via text message.* If you are having a clinical emergency and are unable to reach your therapist, please call the **EMPACT-SPC crisis line at 480.784.1500. This crisis line is available 24 hours a day, 7 days a week. Remember you can always contact 911 for assistance.** If you are also seeing a Psychiatrist, it is advised that you contact her/him in times of emergent need.

## PAYMENT AND FEES

**Payment is due at the time services are rendered in cash or check only. You are financially responsible for your session and payment is expected at the time of your appointment. The normal rate is $200 for the initial assessment and $175 for follow up sessions.** Sessions are generally 45-50 minutes. This rate applies to sessions that occur at the Tempe office location as well as my Chandler equine/office location.

_________ Initial.

**Please note that Dragonfly International Therapy is a private pay based practice only i.e. "out of network" for insurance panels.** In addition, each insurance company's policies are different regarding whether or not they will reimburse you. Should you choose to submit any claims to your insurance company it is your responsibility. Please note that Dragonfly International Therapy will not become an in-network provider for you to obtain reimbursement. At your request, you can have receipt that you can use towards submitting an out of network claim.

_________ Initial.

You will be billed **$175 per hour out of pocket** for the time it takes to conduct any additional requests i.e. write letters, fill out forms, consultations, depositions, appearances, phone calls over 5 minutes, or other paperwork. You will be billed $5.00 and .50 per page for copying your records. Returned checks incur cash only service fee of $35.00 in addition to the original check amount.

_________ Initial.

Scheduling an appointment is a commitment to attend it. **A 24-hour business day's notice is required for changes in appointments. Weekends do not count as business days. Therefore, Monday appointments must be cancelled by the previous Friday. Late cancellations and no shows, for any reason, incur a fee of $110.00 paid in cash or check only. This fee is not reimbursable by any insurance company and is due before rescheduling your next appointment.** *If you have repeated no shows or late cancellations, your therapist may not be the right one for you and can help refer you to another provider.*

_________ Initial.

## MEDICAL INSURANCE AUTHORIZATION

If you are seeking to pursue out of network reimbursement through your insurance company, your signature below authorizes your therapist to communicate with the insurance company should we be contacted. You are also authorizing the release of information about your care to your insurance company. The information often required by insurance companies may include, but is not limited to, diagnosis, prognosis, and treatment goals. It is important for you to understand that if you choose to pursue reimbursement through your private health insurance they have the right to your records for the purpose of verifying that services were delivered as billed.

## CONSENT TO TREATMENT

Your signature indicates that you have had an opportunity to read & review this information & that your questions have been satisfactorily answered. It indicates your willingness to abide by its terms & consent to treatment.

_______________________________________________________ _______________

Client Date

___________________________________________________

Therapist Signature Date _______________

Dragonfly International Therapy
3231 S. Country Club Way, Suite 111, Tempe, AZ 85282
11031 E. Victoria St., Chandler, AZ 85248
(Main) 480.370.7630
www.dragonflyinternationaltherapy.com

---

# NOTICE OF PRIVACY PRACTICES

I. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY**

II. **LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).** I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice. PHI l is "disclosed" when it is released transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this notice. However, I reserve the right to change the terms of this Notice and my privacy policies at anytime. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office. You can also request a copy of this Notice from me or you can view a copy of it in my office.

III. **HOW I MAY USE AND DISCLOSE YOUR PHI** I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of, my uses and disclosures along with some examples of each category.

a. **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:

i. ***For treatment***. I can disclose your PHI to physicians, psychiatrists, psychologist and 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 can disclose your PHI to your psychiatrist in order to coordinate your care.

ii. ***To obtain payment for treatment***. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

iii. ***For health care operations***. I can disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to

evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.

iv. ***Other disclosures***. I may also disclose your PHI to others without your consent in certain situations. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

b. **Certain uses and Disclosures Do Not Require Your Consent**. I can use and disclose your PHI without your consent or authorization for the following reasons:

i. ***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.

ii. ***For public health activities***. For example, I may have to report information about you to the county coroner.

iii. ***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.

iv. ***For research purposes***. In certain circumstances I may provide PHI in order to conduct medical research.

v. ***To avoid harm***. In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.

vi. ***For specific government functions***. I may disclose PHI to military personnel and veterans in certain situations. And I may disclose PHI for national security purposes such as protecting the President of the United States or conducting intelligence operations.

vii. ***For workers' compensation purpose***. I may provide PHI in order to comply with workers' compensation laws.

**viii.** ***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.

c. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

i. ***Disclosures to family, friends, or others***. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

d. **Other Uses and Disclosures Require Your Prior Written Authorization**. In any other situation not described in sections III A, B and C above, I will ask for your written authorization before using or disclosing any of your PHI. 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) of your PHI by me.

IV. **WHAT RIGHTS YOU HAVE REGARDING YOUR PHI** you have the following rights with respect to your PHI.

a. ***The Right to Request Limits on Uses and Disclosures of your PHI***. You have 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.

b. ***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 (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

c. ***The Right to See and Get Copies of Your PHI.*** In most cases you have the right to look at or get copies of your PHI that I have, 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 l collected in connection with a legal proceeding. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 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. If you request copies of your PHI, I will charge you not more that $.45 for each page. 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.

d. **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 April 15, 2004.

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 60 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.

V. **HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES**. If you think that I may have violated your privacy rights, or you disagree with a decision I made about your access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S. W. Washington, D.C. 20201. I will take no retaliatory action against you if you make a complaint about my privacy practices.

VI. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAINT 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 individual provider.

VII. **EFFECTIVE DATE OF THIS NOTICE**. This notice went into effect on April 14, 2004

Dragonfly International Therapy
3231 S. Country Club Way, Suite 111, Tempe, AZ 85282
(Main) 480.370.7630
www.dragonflyinternationaltherapy.com

**NOTICE OF PRIVACY PRACTICES SIGNATURE PAGE**

I hereby acknowledge that I have reviewed and received a copy of the "Notice of Privacy Practices" for Dragonfly International Therapy, the counseling practice of Sarah Jenkins, MC, LPC.

Print name: ___________________________________________________________________________

Signature: ___________________________________________________________________________

Date: ______________________________

Dragonfly International Therapy
3231 S. Country Club Way, Suite 111, Tempe, AZ 85282
(Office) 480.370.7630
www.dragonflyinternationaltherapy.com

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I the undersigned, hereby authorize **Dragonfly International Therapy** to disclose my Private Health Information to the below named entity.

List the Name, Phone, & Address of the Source to Which Information Is To Be Released:

| | | |
|---|---|---|
| _____Mental Health Records | ______Test Results | ______AIDS/HIV Related Information |
| _____Court/Legal Records | ______School Records | ______Substance Abuse (drug/alcohol) Records |
| _____Consultations | ______Discharge Summary | ______Medical Records (excluding HIV) |
| _____Verbal Information | ______Progress Notes | ______Communicable Disease Information |
| _____Psychosocial History | ______Treatment Plan | ______Crisis Assessments/Interventions |
| _____Psychiatric Evaluation | ______Other (Specify) | _________Entire chart |

I understand that: (a) I may keep a copy of this form after I sign it, and/or I may request a copy from the named clinician; (b) treatment, payment, enrollment, or eligibility for benefits is not conditioned on my signing this authorization; (c) the information used or disclosed under this authorization may be subject to redisclosure by party information is released to and is no longer the responsibility of the named clinician and may not be protected by federal privacy regulations; and (d) I may revoke this authorization at any time by notifying the named clinician in writing, as described below. This will not affect any action the named clinician took prior to receiving the revocation.

I understand that this authorization will expire on the earlier of (a) twelve months from the date of signature (b) completion of the recommended treatment and all related payment activities, or (c) by the date the undersigned sets here:

_________________________________________ ____________________
Signature of Client or legal representative Date

_________________________________________ ____________________
Printed name Relationship to patient

To The Recipient of This Release of Information:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of other medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Arizona Revised Statues (ARS 36-561) prohibit recipients from secondary disclosure/release of information related to HIV Communicable Diseases, to additional persons/organizations without the specific written consent of the client/guardian.