THROUGH IT ALL COUNSELING - Cristina Yturralde MC, LPC
6619 N Scottsdale Rd.
Scottsdale, AZ 85250
(480) 740-8909
cy@throughitallcounseling.com

Welcome!

I want to thank you for scheduling an initial appointment to meet with me.

I look forward to learning about you, your current concerns and your goals for therapy. After listening and asking a variety of questions, I will share my impressions of how I may be able to assist you in achieving your goals or I will give you the names of other providers or resources in the area that may better serve you.
Please find enclosed my Office Policies and Forms for you to fill in before you come to your first session. Please feel free to either email, fax these in before our initial session or bring them with you.
You will find in this package:

- **Intake form/child intake form - please fill in the best you can. This is background info.**
- **Informed consent - this is a description of your rights to confidentiality along with my office policies. If you have any questions, please feel free to ask me during our sessions.**
- **HIPPA form - rights to confidentiality explained in the Notice of Privacy Practices. By signing this form (last page) it is acknowledging that I have given you a copy of the Notice of Privacy Practices.**
- **Directions to my office**
- **Financial Consent**

If you have any further questions please do not hesitate to call me at (480) 740-8909. I look forward to meeting with you.

Sincerely,

Cristina Yturralde MC, LPC

Cristina Yturralde **MC, LPC**

6619 N Scottsdale Rd.
Scottsdale, AZ 85250
480-740-8909

Method of Payment

_Self Pay _Insur. _Other

Personal Information (Please Print Clearly) Today's Date ____ _

Client Name:----------.,-
Last First Middle

Address: _____ _
Street City State Zip

Phone: (__) (___J (___J (___J. _____
Home Work Cell

Which# would you prefer me to call? __ Can I leave a message? *YIN* Do you receive texts? *YIN*

Birthdate: _____ SSN: _____ Religious Preference: ____ _

Email ----------

Marital Status:

[ ] Single [ ] Divorced [ ] Separated [ ] Widowed
[ ] Married-Name of Spouse _____ Date of Birth _____ _

Employment Status:

[ ] Full-time [ ] Part-time [ ] Homemaker [ ] Student [ ] Retired [ ] Unemployed

Employer: _____ Position: _____ _ **RESPONSIBLE PARTY/INSURANCE**

PROVIDER INFORMATION:

Responsible Party: _____ SSN: _____ DOB: ____

Policy Holder: _____ SSN: _____ DOB: ____

Address: _____ Phone:(__) _____ _

Insurance Co.: _____ ID#: _____ Group #: _____

Billing Address: _____ _ Phone Number: - ------- --- Effective Date: ----------

Note: Verification of benefits is not a guarantee of payment, but is just a summary of benefits available.
Final determination is made upon receipt of the claim and review of all documentation.
Client Relationship to Insured: [ ] Self [ ] Child [ ] Spouse [ ] Other:

Client Background Information

Please list the persons with whom you are currently living with:

Name	Relation	Age

Client Health History Information

Family Physician:_____ Phone: (___)_____

Current Medical Problems_____

Allergies:_____

In Case of Emergency, Please Notify _____

Name Relationship Phone

How Did You Hear About My Practice? (Referral Source):_____

Presenting Problem and Reason for Referral?:_____

_____

Why Are You Seeking Help Now?:_____

_____

Have You Previously Sought Professional Counseling or Psychiatric Consultation?

Yes___ No__ (If "yes", *please state the name of the mental health professional/s and the date/s of* treatment):_____

Have You Ever Been Hospitalized For a Mental Health Condition? Yes _No_ (If 'yes"' please explain): _____

). Are You Currently Taking Any Medication on a Daily Basis? Yes_No ___(If "yes", what is/are the name/sand dosage of the medication?): _____

l. Do You Have Any Health Conditions That Adversely Impact Your Daily Routine? Yes_No_(If "yes", please explain): _____

?. Do You Currently Have Suicidal Thoughts? Yes_ No_ Unsure_

J. Have you Previously Had Suicidal Thoughts? Yes_No_Unsure_

t. Have You Ever Attempted to Commit Suicide or Self-Injure Yourself (i.e. cut, burn, etc)? Yes_No_(If "yes", please explain what happened):_____

_____

_____

;, Do You Currently Have Thoughts of Wanting to Seriously Harm or Kill Someone? Yes___ No____

5. Do you Currently Experience Drug or Alcohol Problems? Yes ___ No___

7. Have You Previously Struggled With Drug or Alcohol Issues? Yes, Drug_ Yes, Alcohol_ No____

t Have You Ever, As a Child, Been A Victim of Physical or Sexual Abuse? Yes___No___ Unsure___

). Are You Currently Being Abused? Yes, Physical__ Yes, Sexual__ Yes, Emotional__ No___ Unsure__

). Are You Currently Involved in Any Form of Litigation? (i.e. court proceedings) Yes_No_ (If'yes", please explain):_____

[. Have You Ever Been Arrested For Any Civil or Criminal Action? Yes___ No___

Comments?_____ _____

FAMILY BACKGROUND QUESTIONNAIRE

PLEASE LIST THE MEMBERS OF YOUR CURRENT FAMILY, INCLUDING AGES AND OCCUPATIONS. PLEASE BE SURE TO STATE IF FAMILY MEMBERS ARE BIOLOGICAL, ADOPTIVE, OR OTHER

PLEASE CHECK ANY PAST OR IMPENDING ISSUES THAT APPLY TO YOU, YOUR PARENTS AND/OR SIBLINGS?

	SELF	MOTHER	FATHER	SIBLING(S) (SPECIFY)
ALCOHOL ABUSE				
DRUG ABUSE				
EMOTIONAL PROBLEMS				
PSYCHIATRIC HOSPITALIZATIONS				
ANXIETY				
DEPRESSION				
OTHER MENTAL ILLNESS				
ULCERS OR COLITIS				
ASTHMA				
SERIOUS PHYSICAL ILLNESS				
WEIGHT/EATING PROBLEMS				
ANOREXIA				
BULIMIA				
INSOMNIA				
ATTEMPTED/ COMPLETED SUICIDE				
EPILEPSY				
PHYSICAL ABUSE				
SEXUAL ABUSE				
DEBILITATING INJURIES/DISABILITIES				
NUMEROUS CHILDHOOD ILLNESSES				
FREQUENT RELOCATIONS				
LEARNING PROBLEMS				
DEATHS				
DIVORCE				
FINANCIAL CRISIS/UNEMPLOYMENT				
LEGAL PROBLEMS				
OTHER				

CONFIDENTIAL

Please Circle Any of the Following Problems Which Pertain to You:

Nervousness	Temper	Headaches
Shyness	Children	Memory
Marital Separation	Stomach Problems	Insomnia
Drug Use	PMS	Inferiority Feelings
Anger	Difficulty Sleeping	Career Choices
Sleep	Sexual Dysfunction	Nightmares
Relaxation	Physical Abuse	Appetite
Anxiety	Sexual Abuse	Being a Parent
Legal Matters	Alcohol Use	Divorce
Energy	Self Control	Fears
Loneliness	Stress	Suicidal Thoughts
Education	Friends	Unhappiness
Finance	Tiredness	Concentration
Work	Decision Making	Health Problems
Ambition/Motivation	Bowel Problems	My Thoughts
Marriage	Depression	

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Informed Consent for Assessment and Treatment

Notice of Policies and Practices to Protect the Privacy of Your Health Information

Welcome to my counseling practice. I am committed to assisting you in achieving your goals for our time together. A counseling situation offers a unique relationship between the two of us. In order that we start this relationship in a healthy way, I have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling, professional services and business policies. It also contains information about our policies and practices to protect the privacy of your health information. Please read it carefully and discuss any questions you may have with me. When you sign this document, you will be stating that I provided you with this information and it will represent an agreement between us.

Background and Services.

I am a professional counselor (Cristina Yturralde MC, LPC) I have an independent private counseling practice (Through It All Counseling). My credentials include a Master's degree in Counseling and I am licensed by the Arizona Board of Behavioral Health Examiners. I offer counseling and psychotherapy to individuals, families and children in the areas of mental health, relationships, and adjustment. Although I do share the offices with several other therapists, my practice is independent from them. I do not provide care or treatment for their clients, and they do not provide care or treatment for my clients.

Psychotherapy Services: Benefits and Risks of Counseling Services

Psychotherapy varies depending on the therapist, the client and the client's particular· situations and goals. There are many different methods I may use to deal with your particular situations and goals. In order for therapy to have the best outcome you will have to invest energy in the process and work actively on things we talk about both during and between our sessions.

Psychotherapy may have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety or frustration when discussing aspects of your life. Counseling may lead to your decision to change behaviors, employment, schooling, housing, relationships, or any other aspect of your life. Sometimes a decision that is positive for you may be viewed negatively by other family members. Change will sometimes be easy and swift, but often is slow and even frustrating. In marriage and family counseling, interpersonal conflict can increase as we discuss family issues. The potential for divorce is a risk in marital counseling. Psychotherapy has been shown to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Treatment Process and Rights

We will begin with one or more sessions for an initial assessment to give me a good understanding of the issues, background, and other factors that may be relevant. When this process is complete, we will discuss options for treatment and develop a treatment plan. This is a mutual process and I welcome your participation in the development and periodic review of the treatment plan. I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experience. If at any time you have questions about any aspect of our work together, please

discuss them with me. If you decide that you do not want to continue therapy with me, please tell me if you want me to help you try to another therapist. You have the right to refuse any recommended treatment or to withdraw consent for treatment at any time.

Sessions: I schedule 45/50-minute sessions with clients usually once per week at a time we agree on. If you arrive late for an appointment, we will only be able to meet for the remaining time of our scheduled 45 minutes. Sometimes I will meet more or less than once per week if that is consistent with a treatment plan we both agree to. If you ever need to cancel a scheduled therapy session, please do so at least 24 hours in advance. If you do not cancel a scheduled appointment with at least 24 hours notice or if you fail to attend a scheduled session, you will be expected to pay the full fee for that session, unless we both agree that you were unable to attend due to circumstances beyond your control. Insurance companies will not reimburse for canceled or missed appointments so you will be fully responsible for the charges for such sessions.
Professional Fees: My fee is $210 for the initial assessment and $140 for continuing *50* minutes sessions. Discounted cash fee is $120 for initial session and $90 thereafter. In addition to my regular sessions, we charge per hour for other professional services you may need, though I will break down the hourly cost into 15-minute increments of work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings or consultations with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other professional service that you may request. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional fee even if I am called to testify by another party. Because of the complexity and difficulty of legal involvement, we charge $250 per hour for preparation and attendance at any legal proceeding including transportation time.

Billing and Payments: You will be expected to pay the full fee, or your full copayment/coinsurance amount if you are using insurance, at the time of each session unless we agree otherwise or unless you have insurance coverage that requires another arrangement. We accept payments by check, cash or credit card. Payment schedules for other professional services will be agreed to when they are requested.
If you make a payment by check and your check does not clear due to insufficient funds or any other reason, you will be expected to reimburse us in full for any related bank fees that we are charged as a result.

Insurance or EAP Reimbursement: If you will be using health insurance or Employee Assistance Program (EAP) benefits, it is important for you to find out exactly what it covers for our sessions. I will be happy to help you understand the mental health benefit information your insurance company or EAP gives to you or me. Please be aware that any benefit inf01mation that you or I receive from your insurance company is always given with a disclaimer from them. They state that the quoted benefits are not a guarantee of payment with that the final determination of coverage will be made only when a claim is submitted. Therefore, it is very important for you to realize that you are fully responsible for the full payment of any service fees that your insurance does not pay for any reason.

If you have insurance coverage for mental health treatment, we will provide assistance in accessing your benefits. Be aware that I am not a provider on all managed care panels. I have agreed to a contracted rate with some insurers, while others may provide out of network benefits even if I am not contracted with them. It is very important that you learn exactly what your insurer will provide for your treatment. For questions regarding coverage, you should call your plan administrator. Please discuss concerns about what your insurer requires with me. I have the right to cancel my participation with any managed care or insurance provider at any time. I notify clients if this occurs and will help to secure a refence to another therapist who may be a network provider if you desire.

In order for me to bill your insurance company or EAP, I will need you to sign an authorization that will allow me to provide them information they require to process claims. This information will include a diagnosis, dates of service and the types of service provided. Some mental health insurance or EAP coverage requires authorization before you begin services and ongoing authorization during our work together. Usually in these cases, the insurance company or EAP will want information from me about your diagnosis and clinical information such as presenting problems, a treatment plan, a treatment summary or other information. Any information I give to your insurance company or EAP will become part of their flies and may be stored in their computer database. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once they have it. Please inform me as soon as possible if your insurance plait or your EAP coverage will be changing.

Contacting Me: l am often not immediately available by phone because l do not answer the phone when l am in sessions with clients. Calls go to my voicemail when I am unavailable, which I check regularly. I will make every effort to return your call as soon as possible during regular business hours (usually within a few hours and almost always within 24 hours). If you are difficult to reach, please leave times you will be available. If you want me to use discretion when calling you or leaving a message for you, please let me know in advance. At times when I will be unavailable for an extended time, I will arrange for a trusted colleague to be available on-call to handle any urgent calls that arise. My practice does not have the capability to respond immediately to all counseling emergencies. These emergencies should be directed to the emergency services (911) or to the local hot lines (Empact 480-784- 1500, Banner Help Line 602-254-4357 or Mercy Maricopa Integrated Healthcare - 602-222-9444.

Professional Records: The laws and standards of my profession require that I keep treatment records. Treatment records are stored in a confidential manner, as required by law. You are entitled to examine and/or receive a copy of your records if you request it in writing unless I believe that seeing them would be emotionally damaging, in which case I will send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to people who are not mental health professionals. Therefore, if you want to see your records, I recommend that you review them with me so we can discuss the contents. I reserve the right to charge you for the costs of copying and sending your records if you request them. In the event of my death, retirement, or incapacity, the records for my clients that are actively receiving services (seen within the last month) will be given to one or more local behavioral health professionals to facilitate the continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment or ask for a referral. A "records custodian" will handle records for my inactive clients, which may be an individual or company. The custodian will be responsible for satisfying records requests and destroying records when the legal time frames for records retention are satisfied.

Our Relationship

The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or pursue friendship. The boundaries ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained.

Confidentiality: In general, the law protects the privacy of all documentation between a client and a therapist. I can only release information about your treatment to others if you sign a written authorization form. You can revoke any such authorizations at any time in writing. However, in the following situations your authorization is not required for me to release information:

If I believe that a client is in immediate danger of attempting serious physical harm to herself/himself, I have an obligation to intervene, which may include pursuing hospitalization and/or contacting family

members, friends or others who can help provide protection. If I believe that a client is likely to attempt serious physical harm to someone else, I have a duty to intervene, which may include contacting the police, warning the intended victim(s) and/or pursuing hospitalization. I am required to report any suspected physical or sexual abuse or neglect of a child under 18 to Arizona Child Protective Services as soon as it comes to my attention. Likewise, I am obligated to report any suspected elder abuse to the appropriate agency if the elderly person is not capable of reporting the abuse herself/himself. Once such reports are made, I may be required to provide additional information. For the situations described above regarding potential harm to self or others and suspected child or elder abuse or neglect, l will try to discuss it with you whenever possible before I take action and I will limit my disclosure to what is necessary.

If you become involved in a court proceeding, in most cases you have the right to prevent me from providing any information about your treatment. However in some proceedings such as those involving child custody or those in which your emotional condition is an important issue, a judge may order my testimony with a court order if she/he determines that the issues require it.

If you file a worker's compensation claim and I am providing treatment in accordance with the Arizona Workers' Compensation law, I may be required to provide a copy of your record to your employer or their appropriate designee.

I may be required to disclose information to a health oversight agency for oversight activities authorized by law such as licensure or disciplinary actions.

If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

I occasionally find it helpful to consult with other professionals about a case. In these consultations I make every effort to avoid revealing the identity of the client and the consultant is legally bound to keep any information discussed confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your record.

In my practice, I may need to share protected health information with an employee for administrative purposes, such as billing, scheduling and quality assurance. Any employee/ partner is bound by the same rules of confidentiality as I am.

Our practice may have some contracts with businesses such as a practice management software company. As required by federal law, we have formal business associate contracts with any such businesses in which they promise to maintain the confidentiality of all data. If you wish, I can provide you with the names of any businesses we contract with and a blank copy of such a contract. While I am not an attorney, please feel free to discuss any questions or concerns you have about confidentiality with me at any time. If you have specific legal questions about the laws regarding confidentiality, the exceptions, and how it may relate to your situation, please seek formal legal advice from an attorney.

Psychotherapy with Minors: When parents bring in their child for treatment, they are understandably curious about their child's progress and parental involvement is often crucial to successful treatment. For all children age 18 or below, parents have the right to request and receive information about their child's mental condition, diagnosis, treatment needs and services provided. It is my belief, however, that young people need to develop trust in their counselor and need some degree of privacy. I ask parents to respect this privacy and refrain from asking me about the details of their child's/children's treatment. If parents request it, I will provide them with general information about how treatment is proceeding. I will inform parents as soon as possible if I believe there is a high risk that their child will seriously harm herself/himself or someone else. Before giving parents any information, I will attempt to discuss it, if possible, with the child and I will do my best to handle any objections she/he may have.

Other Client Rights: If you want, I will discuss with you more details about any of the following:
You have the right to request to receive confidential communications from us by alternate means or at an alternate location.

You have the right to obtain a paper copy of this notice from us, upon request.

You may have the right to have your therapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and your therapist may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you of any changes by making them available, in writing, at our office.

COMPLAINTS:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your therapist of your complaint. We will not retaliate against you for filing a complaint. however, due to the cooperative relationship required for effective mental health therapy, in some circumstances, it may be impossible to continue a therapeutic relationship after a Complaint has been filed.

CONSENT FOR TREATMENT

By signing below I am indicating that I have received, read and understood the statement of Informed Consent for Assessment and Treatment. I have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of these documents. Further, I consent to participate in evaluation, assessment and/or treatment. I understand that I may withdraw from or refuse treatment at any time. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Client Signature (or legal guardian, if minor child) Date_____

X_____

In the case of a minor child, please specify the following:

Full name of minor: _____ DOB. _____ Relationship: _____ _ Therapist _____

Date _____

Receipt of HIPP A Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as 'The Health Insurance Privacy and Accountability Act of 1996' ("HIP AA"). Under HIP AA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received. We are required, by law, to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Your signature below indicates only acknowledgment that you have received this Notice of Privacy Practices.

X. Printed _____ Name _ Date

X _____

Signature

Through It All Counseling / Cristina Yturralde MC, LPC

Financial Agreement

The standard fee for service (a 45-50 minute session) is $140. This is due and payable at the time of service. If your health insurance policy offers mental health coverage, our staff will be glad to verify your insurance coverage for you. However, be aware that we are often given inaccurate or conflicting information, and it is within the rights of the insurance company to deny coverage at any time. Based upon the information we have been given, your benefits are as follows:

- Number of sessions (per calendar year)
- EAP sessions at no charge
- Deductible
- Co-pay/co-insurance (standard/graduated)

Please initial below:

__ I authorize payment for services rendered to the below-named provider.

__ I understand that upon termination of counseling, payment is expected in full for services rendered. (Accounts 90 days past due will be charged 18% interest.)

__ Except for unforeseen and unavoidable accidents or illness, I will give 24-hour notice to cancel an appointment. I understand that I may be billed the full fee for late cancellations and/or missed appointments and that I am fully responsible for this charge, as insurance companies will not cover such charges.

I fully understand that regardless of insurance coverage, I am legally responsible for all fees due the therapist. In the event that collection procedures are instituted for any fees owed by me, I agree to pay reasonable attorney's fees and court costs and give permission for my identity and payment history to be released to the attorney.

Client or Responsible Party Signature Date

Therapist Signature Date

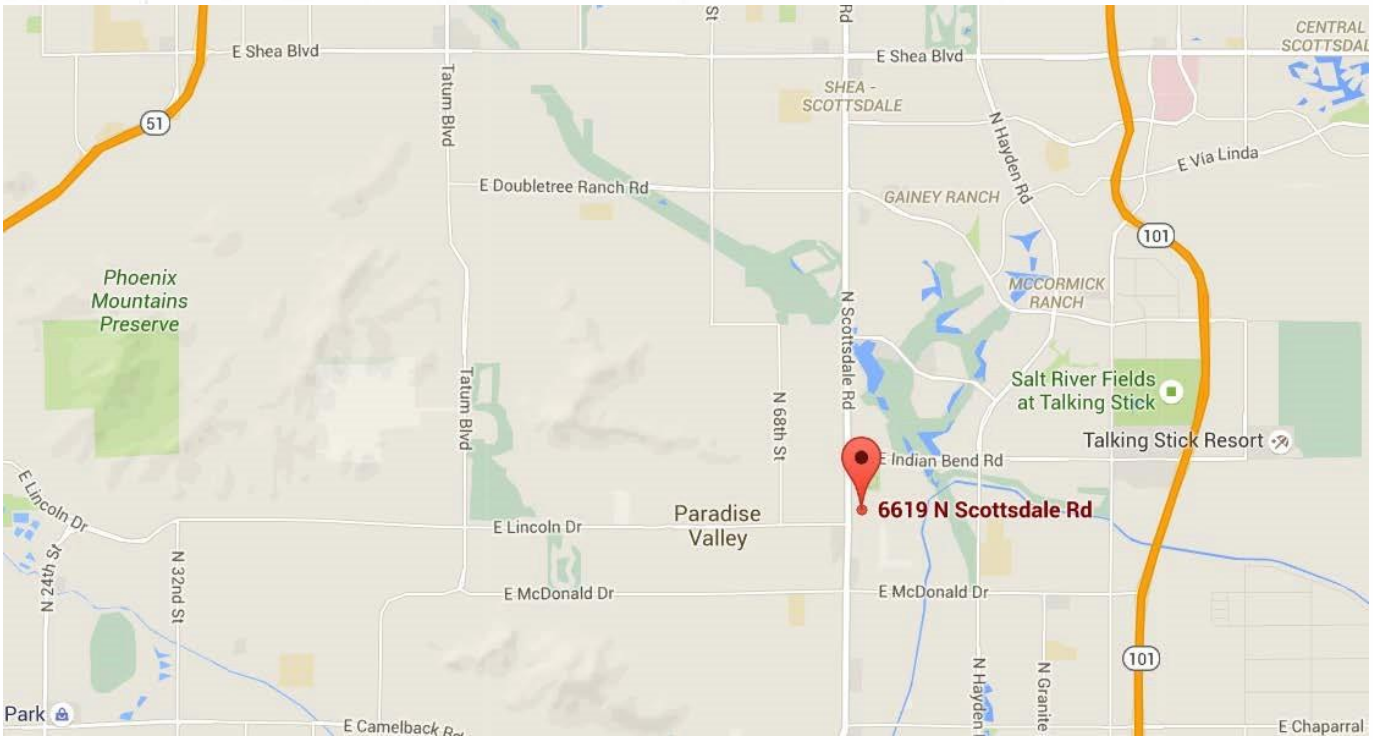
Consent for Treatment

I have fully read and understood the statement of Office Policies and Procedures as well as the Patient Rights and Responsibilities. I have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of these documents. Further, I consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Client or Responsible Party Signature Date

Cristina Yturralde MC, LPC
Through It All Counseling
6619 N Scottsdale Rd.
Scottsdale, AZ 85250
480-740-8909

Directions to the Office:



Through It All Counseling

Cristina Yturralde MC, LPC

Credit Card on File Agreement:

As an authorized signer on the credit card listed below, I give Through it All Counseling and Cristina Yturralde MC, LPC permission to utilize the credit card for all charges related to and including services rendered at Through it All Counseling. Visa/MC Account Number: _____

Expiration Date: _____

Security Code or CID#: _____

Billing Zip Code: _____

Name on Card: _____

Name ofClient(s): _____

Phone Number: _____

Email address: _____

_____ _____

Signature Date