



Welcome to Sonoran Life Solutions!

Sonoran Life Solutions, Inc. is a group practice consisting of providers licensed with the Arizona Board of Behavioral Health. This includes, Licensed Professional Counselors, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Licensed Associate Counselors. We offer individual, couples, and family counseling. We also have counseling interns who are under direct supervision and provide services at a reduced rate.

Our purpose at Sonoran Life Solutions, Inc. is to provide you with psychotherapy services with the utmost professionalism, care, and compassion. Psychotherapy consists of many different methods and modalities. Your assigned Therapist, with your input, will develop a treatment plan with you. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. The purpose of therapy is to assist you in dealing with situations or problems that may be hindering your ability to live a healthy life in which you were meant to live.

Psychotherapy can have benefits, as well as risks. Since therapy will involve sharing your feelings openly with your Therapist, uncomfortable feelings such as anger, sadness, and distress may occur. This is normal, as therapy can often be difficult. There are however many benefits to psychotherapy, including the decrease in distress you may be feeling, improved relationships, more clear decision making, and overall better mental health. You do have the right to withdraw from treatment or refuse treatment at any time and will be advised of possible consequences if any.

We are pleased you have chosen Sonoran Life Solutions, Inc. for your counseling needs. We know there are many choices of providers and really appreciate you choosing us.

Client Name (Print) _____

Client Signature _____ Date _____

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, Inc. will gladly file your insurance claims. Sonoran Life Solutions, Inc. 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 regard 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, Inc. does exercise the right to share your billing information to a collection agency if you have a balance that has been left unpaid more than 90 days. Payment plans for unpaid balances may be an option and would need to be discussed with our Site Managers.

Sonoran Life Solutions, Inc. does have a cancellation policy which requires you to cancel your session at least 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 (1 hour) \$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 \$50.00 administrative charge

Paperwork completed during a session- no charge

Paperwork outside of a regular session \$20.00 per 15 minutes

Late Cancellation/No shows \$50.00

Court Appearances (includes travel and wait time) \$130.00 per hour

Disability related forms are provided after a minimum of two 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 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:

Relationship

	Yes	No	Mother	Father	Brother	Sister	Grandparent
Drugs/Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?
