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.

_____

Name (please print)

_____

Signature of client or legal guardian Date

_____

Therapist signature Date

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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

We confirm appointments via email and text message. We recommend that you sign up for both, so that you might have access to this information in the event of problems with either email or cell phone carriers.

Where may we send your appointment reminders? __Both email and text message __Text only __Email only

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. (SLS) 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. SLS will file claims with your insurance and 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, SLS will look to you for payment of the claim. SLS highly recommends that you become very familiar with your insurance policy and what is and is not covered by your policy. Policies can be somewhat confusing so it may be necessary for you to call your insurance carrier directly to gain clarification about your benefits.

In most cases you will have a co-pay or deductible which will be paid to our office prior to your appointments. When an insurance company pays SLS, any remaining balance will be forwarded to your account. Balances are due and payable within 30 days. SLS does exercise the right to share your billing information with a collection agency if you have an unpaid balance more than 90 days old. Payment plans for unpaid balances may be an option and would need to be discussed with our billing department.

SLS has a cancellation policy requiring you to cancel your appointment at least 24 hours in advance to avoid being charged. SLS does understand there may be extenuating circumstances which prevent you from canceling or coming to your appointment. SLS 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) $175.00
- Individual Therapy Session (53 minutes) $125.00
- Family, Marriage, or Couples Therapy Session (53 minutes) $150.00
- Intern Sessions (40-50 minutes) $65.00
- Life Coach Session (40-50 minutes) $80.00
- Photocopies of Medical Records $0.15 per page and a $50.00 administrative charge
- *Note written request must be completed at the front office.
- Paperwork outside of a regular session $20.00 per 15 minutes (Please be advised, pursuant to A.R.S. 32-3251(16)(m), SLS is unable to complete FMLA and Disability paperwork.)
- Late Cancellation/No shows $50.00 ($75.00 as of 1/1/22)
- Court Appearances (includes travel and wait time) $180.00 per hour
- Late Cancellation/No shows $75.00
- Return Check Fee $25.00

Disability related forms are completed after a minimum of three sessions with your Therapist. If they cannot be completed in session, they will be billed as "paperwork outside of regular session" and payment will be required **PRIOR** to releasing the documentation.

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.

_____

Name (please print)

_____

Signature of client or legal guardian Date

_____

Therapist 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:

_____

Name (please print)

_____

Signature of client or legal guardian Date

_____

Therapist 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.

Individual Counseling _____
Couples Counseling _____
Family Counseling _____

_____
Name (please print)

_____
Signature of client or legal guardian Date

_____
Therapist signature Date

PATIENT HISTORY:

List your family members below.

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:

	Yes	No	Mother	Father	Brother	Sister	Grandparent
Drugs/Alcohol	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐

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?

_____