

Date: _____

CLIENT INFORMATION

Client Name: _____
Last Name, First Name Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ DOB: ____/____/____ Sex: Male Female

 Phone: _____

 Email: _____

HOW DID YOU HEAR ABOUT US:

Google Instagram Facebook

Friend _____
Who can we thank for referring you?

Other _____
Tell us more, we are anxious to know!

REASON FOR APPOINTMENT: _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name: _____ Relationship to Client: _____

 Phone: _____

 Email: _____

PAYMENT METHOD: Cash Check Credit Card



ACCELERATED RESOLUTION THERAPY ACKNOWLEDGEMENT OF RECEIPT

I have read and have been presented with a copy of the following items from Greenlight Therapy Center. I have also been provided a verbal explanation of each of these items.

Please initial:

Client Parent/Guardian

_____ _____ Informed Consent Regarding Treatment and Assessment

_____ _____ Client Rights

_____ _____ Grievance / Conflict Resolution Procedures

_____ _____ HIPAA (Privacy Notice)

Client Signature

Date

Parent / Legal Guardian Signature

Date

Therapist

Date



ACCELERATED RESOLUTION THERAPY INFORMED CONSENT FORM

Accelerated Resolution Therapy (ART) methodology is a form of adaptive information processing which may help the brain unlock maladaptive material. It also appears that ART may avoid some of the long and difficult abreacted work often involved in the treatment of anxiety, panic attack, post-traumatic stress symptoms (such as intrusive thoughts, nightmares, and flashbacks), dissociative disorders, depression, phobias, identity crisis and other traumatic experiences.

I, _____, have also been specifically advised of the following:

- 1) I understand that distressing unresolved memories may surface through the use of ART procedure.
- 2) I understand that some clients experience reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including, but not limited to high levels of emotional or physical sensations. I further understand that distressing memories may seem to disappear, while more pleasant memories may take their place during ART. Therefore, I understand it is my duty to check with my attorney if I need to recall events for a legal procedure. I agree to inform the therapist of such a procedure if applicable.
- 3) I am aware that subsequent to the treatment session, the processing of the incidents and /or material may continue and dreams, memories, flashbacks, feelings, etc., may surface. For some people, this method may result in sharper memory, for others, it may result in fuzzier memory following the treatment.
- 4) I further confirm that I do not have any special medical conditions (pregnancy, heart condition, ocular difficulties, etc.) and have consulted with my medical professionals before participating in ART treatment. ART treatment may put you at risk due to the possibility of heightened emotional reaction from ART treatment.

Before commencing ART treatment, I considered all of the above and obtained whatever additional input and/or professional advice I deemed necessary or appropriate.

I understand that I may stop treatment at any time before or during any ART session and that more than one ART session may be necessary in the treatment.

My signature below, I hereby consent to receive ART treatment. My signature on the acknowledgement and consent is free from pressure or influence from any person or entity. I have thoroughly read the material explaining ART and understand it.

Client Signature

Date

Witness Printed Name/Signature

Date

Each client must be afforded the following basic rights:

1. To be treated with dignity, respect and consideration;
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age disability, marital status, diagnosis, or source of payment;
3. To receive treatment that:
 - a. Supports and respects the client's individuality, choices, strengths and abilities;
 - b. Supports the client's personal liberty and only restricts the client's personal liberty according to a court order; by the client's general consent; or as permitted in this Chapter; and
 - c. Is provided in the least restrictive environment that meets the client's treatment needs;
4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category of rights;
5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;
6. To have grievances considered by a licensee in a fair, timely and impartial manner;
7. To seek, speak to and be assisted by legal counsel of the client's choice, at the client's expense;
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting or exercising the client's rights;
9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting or exercising the client's rights;
10. To have the client's information and records kept confidential and released only as permitted under R9-20-211(A)(3) and (B);
11. To privacy in treatment, including the right not to be fingerprinted, photographed or recorded without general consent, except:
 - a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
 - b. For a client receiving treatment according to A.R.S. Title 36, Chapter 37;
or
 - c. For temporary video recording used for security purposes;
 - d. AS provided in R9-20-602(a)(5);
12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211(A)(6);
13. To review the following at the agency or at the Department:
 - a. This Chapter;
 - b. The report of the most recent inspection of the premises conducted by the Department;
 - c. A plan of correction in effect as required by the Department

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- d. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency; and
 - e. If the licensee has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency;
14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health services except for a crisis service;
 15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment and alternatives to the proposed treatment;
 16. To be offered or referred for the treatment specified in the client's treatment plan;
 17. To receive a referral to another agency if the agency is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
 18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;
 19. To be free from:
 - a. Abuse;
 - b. Neglect;
 - c. Exploitation;
 - d. Coercion;
 - e. Manipulation;
 - f. Retaliation for submitting a complaint to the Department or another entity;
 - g. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the client's treatment needs;
 20. To participate or, if applicable, to have the client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the client's written treatment plan;
 21. To participate or refuse to participate in research or experimental treatment;
 22. To give informed consent in writing, refuse to give informed consent, or withdraw informed consent to participate in research or in treatment that is not a professionally recognized treatment;
 23. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
 24. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility, according to the agency's policies and procedures.

Greenlight Therapy Center, has a way for clients to make complaints and to have problems solved. Clients may also complain directly to the Department of Health Services regarding violations of licensing standards, statutes or rules.

The phone number and address of the Department of Health Services has been listed on the following page and is provided for clients, family members, custodial agencies, and guardians or designated representatives.

You have the right to make a formal complaint about anything or anyone at Greenlight Therapy Center, including if you feel you have been discriminated against because of your race, color, national origin, sexual orientation, age, handicap, or source of payment.

All complaints or grievances will be considered in a fair, timely, and impartial manner.

Greenlight Therapy Center, will not discharge or discriminate in any way against any youth by whom or in whose behalf a complaint has been submitted to DHS or who has participated in a complaint investigation process.

You will be explained the following procedures for filing complaints within 24 hours of arrival.

1. Client to tell any staff member that there is a complaint to be made.
2. Staff will then provide youth with the appropriate form and immediately allow the youth to write the complaint or assist the youth in writing the complaint if assistance is needed.
3. The staff member receiving the complaint will then make a copy of the complaint and give it to the youth.
4. Allow the youth and/or the staff to give the complaint to the Program Manager.
5. The Program Manager will attempt to resolve the complaint and document the proposed resolution within 5 working days.
6. The client will then be given the opportunity to sign the resolution noting whether or not it is accepted or denied.
7. If the resolution is accepted, staff will ensure that the proposed action is completed.
8. If the resolution is appealed, the complaint will be forward to the Executive Director.
9. The Executive Director will attempt to resolve the complaint within 2 business days.
10. The Executive Director's decision is final at the agency level.
11. All complaints will be maintained on file.

You have the right to contact the following agencies:

- Arizona Department of Health Services, Division of Licensing
150 N. 18th Ave, Suite 410; Phoenix, Arizona 85007 Phone: 602-364-2639

- Office of Human Rights Advocates
150 N. 18th Ave. 2nd Floor Phoenix, AZ 85007 Phone: 602-364-4585

- Mercy Care, Maricopa County's R.B.H.A. Phone: 800-624-3879

- Arizona Center for Disability Law Phone: 602-274-6287

- Child Abuse Hotline Phone: 888-767-2445

If you have any questions regarding the Grievance Procedure, please ask any staff present, or feel free to contact Greenlight Therapy Center at any time in the future regarding questions over the grievance procedure or any of the above information provided.

Client Signature

Date

Parent/Guardian

Date

Staff/Witness

Date

Greenlight Therapy Center
5235 E Southern Ave #D106-606 Mesa, AZ 85206 P: 480.634.1163 F: 480.634.1952

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Greenlight Therapy Center Privacy Notice, detailing how my information may be used and disclosed as permitted under Federal and Statelaw. I understand the contents, and I request the following restriction(s) concerning the use of my protected health information:

Client Signature: _____

Date: _____

Guardian Signature: _____

Date: _____

Relationship: _____

If not signed by client, please indicate relationship to client (e.g. parent, guardian or spouse).

Witnessed by: _____

*(Therapist or Staff signature required)***INTERNAL USE ONLY**

If the client or client's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to the client and sign below.

Presented on (date and time): _____

By: (name and title): _____

Reason for refusal: _____

**** The Privacy Policy is included in your "Client Copy" Packet ****

PRIVACY NOTICE

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

This document describes the type of information we gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your health information and the right to approve or refuse the release of specific information except when the release is required by law. If the practices described meet your expectations, there is nothing you need to do. If you prefer that we not share information we may honor your written request in certain circumstances described below. If you have any questions about this notice, contact our Privacy Officer at the address below.

Who Will Follow This Notice

This notice describes Greenlight Therapy Center practices regarding the use of your health information and that of:

- Any health care professional authorized to enter information into your chart or medial record.
- All employees, staff and other personnel who may need access to your information.
- All entities, sites and locations of Greenlight Therapy Center follow the terms of this notice. In addition, these entities,sites and locations may share protected information with each other for treatment, payment or health care purposes described in this notice.

Our Pledge Regarding Health Information:

We understand that health information about you and your health is personal. Protecting health is personal. Protecting health information about you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Greenlight Therapy Center whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose protected health information (PHI) about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information. To help clarify these terms, here are some definitions:

- *“PHI”* or health information refers to information in your health record that could identify you.
- *“Use”* applies only to activities within my office, practice group, and staffing, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *“Disclosure”* applies to activities outside of my office, practice group, and staffing, such as releasing, transferring, or providing access to information about you to other parties.

We are required by law to:

- Keep health information that identifies you private;
- Give you this notice of your legal duties and privacy practices with respect to health information about you and;
- Follow the terms of the notice that is currently in effect.

I. How We May Use and Disclose Health Information about You

For Treatment: We may use health information about you with treatment or services. We may disclose health information about you when coordinate or manage your health care and other services related to your health care, such as your family physician, psychologists, court reports or any probation requirements, if applicable or other health care professionals who are involved in taking care of you.

For Payment: We may use and disclose health information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. We may also and disclose health information about you to obtain prior approval or to determine whether your insurance will cover the treatment.

For Health Care Purposes: We may use and disclose health information about you for health care purposes. This is necessary to make sure that all of our clients/consumers receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, interns, psychologists, and other personnel for review and learning purposes. We may remove information that identifies you from this set of health information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment for treatment.

Treatment Alternatives: We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with clients/consumers need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process.

II. Uses and Disclosures Requiring Authorization:

Greenlight Therapy Center may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosure. In those instances, when Greenlight Therapy Center is asked for information for purposes that is not set out in this notice and outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. Greenlight Therapy Center will also need to obtain an authorization before releasing your Psychotherapy Notes for purposes outside of treatment, payment or health care operations. “Psychotherapy Notes” are notes we have made about our conversation during a private, group, joint, or family counseling session, which Greenlight Therapy Center have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (a) Greenlight Therapy Center relied on that authorization; or (b) if the authorization was obtained as a condition of payment or obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy. If you revoke your permission, thereafter, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

III. Uses and disclosures with Neither Consent nor Authorization:

Victims of Abuse, Child Abuse, Neglect or Domestic Violence: We may disclose protected health information about you whom Greenlight Therapy Center believes to be a victim of abuse (i.e. child abuse), neglect, or domestic violence to a government authority, including a social services or protective services agency, authorized by law to received report of such abuse, neglect or domestic violence:

Adult and Domestic Abuse: We have the responsibility for the care of an incapacitated or vulnerable adult, we are required to disclose PHI when we have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property as occurred.

Law Enforcement: We may release health information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. If you communicate to any personal of Greenlight Therapy Center an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and we believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If we believe there is an imminent risk that you will inflict serious harm on yourself, we may disclose information in order to protect you.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law for purposes of preventing or controlling disease, injury, or disability. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services Greenlight Therapy Center provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative, in response to a subpoena, discovery request, or other lawful order from a court. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Worker's Compensation: We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Protective Services for the President, National Security and Intelligence Activities: We may release health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

As Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

Special Situations:

- Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the armed forces, we may release health information about you as required by military command authorities.
- Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about clients/consumers of the agency to funeral directors as necessary to carry out their duties.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution.

IV. Your Rights Regarding Health Information About You.

You have the following rights regarding health information we maintain about you:

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care for as long as the PHI is maintained in the record. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy health information that may be used to make decisions about, you must submit your request in writing to our Privacy Officer at the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by Greenlight Therapy Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by Greenlight Therapy Center
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosure: You have the right to request an “accounting of disclosure.” This is a list of the disclosures we made of health information about you.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice by other means, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request one in writing from our Privacy Officer at the address below.

V. Complaints And Changes to This Notice:

You may file a complaint with Greenlight Therapy Center or directly to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with Greenlight Therapy Center by notifying our Privacy Officer of your complaint in writing. Greenlight Therapy Center will not intimidate, threaten, coerce, discriminate against or take other retaliatory action against any individual for filing of a complaint, for testifying, assisting, participating in any manner in an investigation, any compliance review, proceeding or hearing.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain on the first page, in the top left hand corner, the effective date.

Privacy Officer

Melony Opheim
Executive Director / Clinical Director
Greenlight Therapy Center
3707 E Southern Ave. #1014
Mesa, AZ 85206