

**Harvey Shubert, Ph.D.**  
 4115 East Valley Auto Drive, Suite 208  
 Mesa, AZ 85206  
 480-507-7880 ♦ Fax 480-507-8103

Date: \_\_\_\_\_

**Client Information Form**

Note: All information on this form is considered strictly confidential within the guidelines of the clinic.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address 1: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address 2: \_\_\_\_\_ City: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ State: \_\_\_\_\_  
 Cellular Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Date of Wedding: \_\_\_\_\_  
 Previous Marriage: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Previous Wedding: \_\_\_\_\_

**Spouse/Significant Other Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address 1: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Address 2: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Please describe the reason for your visit to our clinic? \_\_\_\_\_

How distressing is this issue for you (on a scale of 1-10: 1=not distressing, 10=most distressing)? \_\_\_\_\_

How does this affect your ability to function occupationally, socially, emotionally, and spiritually? \_\_\_\_\_

How long have you been experiencing distress about this issue? \_\_\_\_\_

**Background Information**

**Parents**

<u>Name:</u>	<u>Age:</u>	<u>Job/Retired:</u>	<u>Physical/Emotional/Mental Problems</u>
_____	_____	_____	_____
_____	_____	_____	_____

**Siblings**

<u>Name:</u>	<u>Age:</u>	<u>Job/Retired:</u>	<u>Physical/Emotional/Mental Problems</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Child(ren)**

<u>Name:</u>	<u>Age:</u>	<u>Job/Grade</u>	<u>Physical/Emotional/Mental Problems</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Symptoms/Issues**

- \_\_\_\_\_ Suicidal Thoughts
- \_\_\_\_\_ Anxious, Worried
- \_\_\_\_\_ Confused
- \_\_\_\_\_ Depressed Moods
- \_\_\_\_\_ Difficulty Being Alone
- \_\_\_\_\_ Fatigued
- \_\_\_\_\_ Guilt Feelings, Shame
- \_\_\_\_\_ Hearing Voices/Hallucinations
- \_\_\_\_\_ Memory/Concentration Problems
- \_\_\_\_\_ Mood Swings
- \_\_\_\_\_ Motivation Reduced/Absent
- \_\_\_\_\_ Obsessive Thoughts
- \_\_\_\_\_ Panic Attacks
- \_\_\_\_\_ Physical Abuse
- \_\_\_\_\_ Low Self-Esteem
- \_\_\_\_\_ Sexual Abuse
- \_\_\_\_\_ Sleep Problems
- \_\_\_\_\_ Unusual Thoughts
- \_\_\_\_\_ Other

- \_\_\_\_\_ Anger, Aggression, or Violence
  - \_\_\_\_\_ Drug/Alcohol Abuse
  - \_\_\_\_\_ Eating Habits/Problems
  - \_\_\_\_\_ Lying Frequently
  - \_\_\_\_\_ Perfectionist
  - \_\_\_\_\_ Physically Abuse Self
  - \_\_\_\_\_ Shy, Uneasy With Others
  - \_\_\_\_\_ Unassertive
  - \_\_\_\_\_ Unwanted Behavior/Habits
  - \_\_\_\_\_ Withdrawn
  - \_\_\_\_\_ Employment/School Issues
  - \_\_\_\_\_ Legal Problems
  - \_\_\_\_\_ Living Arrangements
  - \_\_\_\_\_ Money Management Issues
  - \_\_\_\_\_ Parenting Issues
  - \_\_\_\_\_ Relationship/Marital Issues
  - \_\_\_\_\_ Weight Changes
- \_\_\_\_\_ Increase \_\_\_\_\_ Decrease

**Medical History**

Date of last physical exam: \_\_\_\_\_ Results: \_\_\_\_\_  
 Medical concerns in the last year: \_\_\_\_\_  
 Chronic illnesses: \_\_\_\_\_  
 Surgeries: \_\_\_\_\_  
 Disabilities: \_\_\_\_\_  
 Current medications/reasons prescribed: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Psychological History**

1. Current psychological medications/dosages: \_\_\_\_\_  
 \_\_\_\_\_

2. Counseling (current or previous):

Dates: From - To	Clinic	Therapist	Reason
_____	_____	_____	_____
_____	_____	_____	_____

3. Psychiatric Hospitalizations

Dates: From - To	Hospital/Clinic	Therapist	Reason
_____	_____	_____	_____
_____	_____	_____	_____

**Abuse Issues:**

Please indicate (✓) areas of abuse that you have encountered (□ Not Applicable)

	Past	Current
Physical Abuse		
Sexual Abuse		
Verbal Abuse		
Emotional Abuse		
Physical Neglect		
Emotional Neglect		

Please indicate (✓) areas of abuse by you: (□ Not Applicable)

	Past	Current
Physical Abuse		
Sexual Abuse		
Verbal Abuse		
Emotional Abuse		

**Chemical Use:**

Past Use	Type	Quantity	Frequency	Date Started (if applicable)	Date Ended (if applicable)
Alcohol					
Tobacco					
Illicit Drugs					

In the last year, what alcohol and/or mood altering drug have you used? (Include how much & how often)

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What is the maximum number of drinks you have had on any given day in the past year? \_\_\_\_\_

Have there been any undesirable results of your chemical use? [ Yes ] [ No ]  
 (low job or school performance, physical/health problems, relationship problems, DWI's, legal)

Have you ever been concerned about your own chemical use? [ Yes ] [ No ]

Have others expressed concern about your chemical use? [ Yes ] [ No ]

Have others who are close to you abused alcohol or drugs? [ Yes ] [ No ]

If yes, who? (include family and friends)

Have you ever attended a self-help group such as AA, NA, Al-Anon, ACA? [ Yes ] [ No ]

Are you currently attending a self-help group or support group? [ Yes ] [ No ]

Name of group: \_\_\_\_\_

Describe your daily caffeine consumption? (include coffee, tea, pop, chocolate) \_\_\_\_\_



**CURRENT WELL-BEING**

1. At the present time, how upset or distressed have you been feeling?  
 ① Not at all distressed     ④ Very distressed  
 ② Slightly distressed     ⑤ Extremely distressed  
 ③ Pretty distressed
2. At the present time, how energetic and healthy have you been feeling?  
 ① Not at all energetic and healthy  
 ② Slightly energetic and healthy  
 ③ Pretty energetic and healthy  
 ④ Very energetic and healthy  
 ⑤ Extremely energetic and healthy
3. At the present time, how well do you feel that you are getting along emotionally and psychologically?  
 ① Quite poorly; I can barely  
 ② Fairly poorly; life is pretty tough for me at times  
 ③ So-so; I manage to keep going with some effort  
 ④ Fairly well; I have my ups and downs  
 ⑤ Quite well; I have no important complaints  
 ⑥ Very well; much the way I would like to
4. At the present time, how satisfied have you been feeling with your life?  
 ① Not at all satisfied     ④ Very satisfied  
 ② Slightly satisfied     ⑤ Extremely satisfied  
 ③ Pretty satisfied

**CURRENT LIFE FUNCTIONING**

Please rate how much difficulty you are having in the following areas of your life:	No Difficulty	Some Difficulty	A Lot of Difficulty	Extreme Difficulty
1. Ability to perform routine tasks				
2. Ability to maintain my personal appearance				
3. Ability to concentrate and complete tasks				
4. Participation in physical activities				
5. Ability to function as an independent person				
6. Ability to manage my finances				
7. Being the kind of person I would like to be				
8. Maintaining good health habits				
9. Interactions with people at work				
10. Performance at work or school				
11. Developing or managing my career				
12. Creative activities				
13. Attending work/school or getting there on time				
14. Interactions with my spouse/romantic partner				
15. Interactions with my parents				
16. Interactions with my brothers or sisters				
17. Ability to form or sustain intimate relationships				
18. Enjoyment of sexual activities				
19. Carrying out family responsibilities				
20. Interactions with friends				
21. Participation in social activities				
22. Planning and enjoying leisure time activities				
23. Ability to control myself and stay out of trouble				
24. Ability to be comfortable with people				

# PATIENT LETTER OF AGREEMENT

## INSURANCE BILLING AND PAYMENT POLICY

PLEASE INITIAL EACH ITEM BELOW

\_\_\_\_\_ I request Harvey Shubert, Ph.D. to submit billing on my behalf directly to my insurance carrier.

\_\_\_\_\_ I authorize the release of any information necessary to process the claim for payment.

\_\_\_\_\_ Payment liability for Non-insured patients and for charges of DENIED services rests with the patient, or responsible party, who is the beneficiary of those services.

\_\_\_\_\_ I agree to be personally responsible for payment of those services, as well as, any legal fees, court costs, collection fees, and late fees connected with collection of payment.

\_\_\_\_\_ I agree to pay a **\$25.00** fee for any personal checks returned for insufficient funds.

\_\_\_\_\_ I agree that the person who brought the child in to see the doctor, is responsible for all the fees associated with the visit.

## APPOINTMENT POLICY

\_\_\_\_\_ The cooperation of each patient is necessary to assure that everyone's needs are met. Frequently, patients are placed on a "waiting list" for appointment cancellations. It is therefore necessary that every consideration be given to avoid missed appointments that could be used by someone else.

\_\_\_\_\_ Each patient is responsible for keeping appointments with his or her provider. If it becomes necessary to break an appointment, it is EXPECTED that a patient contact this office 24 hours in ADVANCE of scheduled appointment.

\_\_\_\_\_ If a patient misses his or her scheduled appointment or fails to provide 24 hours advance notice, there will be a charge of **\$50.00**. This charge will not and cannot be billed to your insurance company. You are personally responsible for this charge. **In the event my account is turned over for collection. I understand that I will be responsible for all collection costs.**

SIGNATURE OF AGREEMENT

WITNESSED BY:

\_\_\_\_\_

\_\_\_\_\_

DATE \_\_\_\_\_

DATE \_\_\_\_\_

## INFORMED CONSENT FOR TREATMENT

I \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

1. I have been informed of my rights and responsibilities as a patient of Dr. Harvey Shubert, Ph.D.
2. I have been informed about the limits of confidentiality of my records.
3. I have been informed of the cost of services from Dr. Harvey Shubert. I understand that I am responsible to pay a co-pay and that it is payable each time I come for treatment.
4. I have been informed of Dr. Harvey Shubert's qualifications.
5. I understand that I may address any concerns or grievances with my therapist/doctor at any time. I understand that I may also contact the licensing board which regulates therapist's/doctor's professional practice.
6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time. However, I agree to let Dr. Shubert know before stopping treatment.
7. I agree that if at any time I feel that I may be a threat to myself or others, I will call Dr. Shubert or Banner Helpline (602) 254-4357 before calling 9-1-1.
8. I give my authorization and consent to receive outpatient diagnostic and treatment services from Dr. Harvey Shubert. I understand that my therapist/doctor believes that this treatment will help me and there is no guarantee as to the result. I also understand that on occasion there are negative consequences to treatment and I agree to inform Dr. Harvey Shubert if there are unexpected changes in my condition.

\_\_\_\_\_  
Signature of patient or legal consentor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of staff providing the information

**Harvey Shubert,, Ph.D.**  
4115 E. Valley Auto Drive, Ste. 203, Mesa, AZ 85206  
TEL: (480) 507-7880 FAX: (480)507-8013

## List of Medicines

List/Name of Meds	Dosage	Reason for Taking
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		



**Harvey Shubert, Ph.D.**  
**4115 E. Valley Auto Drive, Suite 208**  
**Mesa, AZ 85206**  
**Phone: 480-507-7880**  
**Fax: 480-507-8013**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ acknowledge that I have received a copy of Harvey Shubert, Ph.D. Notice of Privacy Practices. This notice describes how Harvey Shubert, Ph.D. may use and disclose my protected health information, certain restrictions on the use of my healthcare information, and rights I may have regarding my protected health information.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

**Harvey Shubert, Ph.D.**

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY**

This notice tells you about the ways in which Harvey Shubert, Ph.D. may collect, use, and disclose your protected health information and your rights concerning your protected health information. "Protected Health Information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by Federal and State laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards. The HIPAA Privacy Rule for the first time creates national standards to protect individuals' medical records and other personal health information.

**HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

**PAYMENT:** We use and disclose your protected health information to your insurance company in order to receive payment for your covered health expenses.

**HEALTH CARE:** We may use and disclose your protected health information to other health care providers (physicians, healthcare professionals, laboratories, or hospitals) to better assist in your diagnosis and treatment.

**MEDICAL RECORDS REQUEST:** We will disclose your protected health information if we receive a request from another physician who is treating you or will be treating you, with a signed request from you. We will disclose your protected health information to another physician if we refer you to that physician. We will disclose your protected health information to an insurance company if we have filed a claim on your behalf. We will disclose your protected health information, with your authorization, to a life insurance underwriter or health insurance company if you are seeking life or health insurance coverage and have requested a company to contact us for your medical history.

**MARKETING:** If our office ever decides to use a patient's protected health information for marketing purposes, a patient's prior written authorization to use this patient's information will be required. Daniel J. Christiano, Ph.D. will never sell lists of patient's name/information to any third party.

**OTHER PERMITTED OR REQUIRED DISCLOSURES**

**As Required by Law:** We must disclose protected health information about you when required to do so by law.

**Parents & Minors:** State law governs disclosures to parents:

**Patients 18-22:** who are financially dependent on their parents, yet legally are adults: Without prior authorization, we cannot disclose an adult patient health status to anyone including parents (and in some cases, we cannot disclose a minor's individual health data).

**Children under 18:** It is our office policy that any child under the age of 18 must be accompanied by a parent or legal guardian on their first visit to our office. The parent or representative may then sign an authorization for treatment of the child when they are not with them.

General Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.

Victims of Abuse, Neglect, or Domestic Violence. We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.

Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process, and disclose records to legal counsel for the purpose of seeking legal advice.

Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Coroners, Funeral Directors, Organ Donations. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.

Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Government Functions. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Government Functions. We may disclose protected health information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

#### OTHER USES OR DISCLOSURES WITH AN AUTHORIZATION

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, effective with the date of the letter of revocation.

#### YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that our office maintains about you.

RIGHT TO ACCESS YOUR PROTECTED HEALTH INFORMATION. You have the right to review or obtain copies of your protected health information records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying, mailing your requested information, but we will tell you the cost in advance.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION If you feel that the protected health information maintained by our office is incorrect or incomplete, you may request that we amend the information. Our request must be made in writing and must include the reason you are seeking a change. We may deny your request, for example, you may ask us to amend something in your record that was not created by our office, as is often the case when the information may come to us from another physician, health care professional, laboratory, or

hospital. We may deny your request if you ask us to amend a record that is already accurate and complete.

If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

**RIGHT TO AN ACCOUNTING OF DISCLOSURES BY THE PLAN.** You have the right to request an accounting of disclosures we have made of your protected health information. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years, and may not include dates before September 21, 2009. Your request should indicate in what form you want the list (example: on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists, we reserve the right to charge for the cost of providing the list.

**RIGHT TO REQUEST RESTRICTIONS ON THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment, or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, tell us: (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

**RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS.** You have the right to request that we use a certain method to communicate with you if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**FOR INFORMATION REGARDING EXERCISING YOUR RIGHTS.** You may exercise any of the rights described above by contacting Dan Bernal. See the end of this Notice for the contact information.

#### **HEALTH INFORMATION SECURITY**

Harvey Shubert, Ph.D. requires its employees and associates to follow the the office security policy and procedures that limit access to health information about patients to those employees and associates who need it to perform their job responsibilities. In addition, Harvey Shubert, Ph.D. maintains administrative, and technical security measures to safeguard your protected health information.

#### **CHANGES TO THIS POLICY**

Harvey Shubert, Ph.D. reserves the right to change the terms of the Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in the Notice.

#### **COMPLAINTS**

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing and sent to the Office listed at the end of this Notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

### RIGHT TO REVOKE HEALTH CARE AUTHORIZATION

You have the right to revoke the HEALTH CARE AUTHORIZATION FORM, in writing, at any time. However, your written request to revoke your AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on our authorization. You may revoke your AUTHORIZATION by mailing or hand delivering a written notice to our office at the address listed at the end of the Notice. The revocation is not effective until it is received by our office.

The written notice must contain the following information:

- Your name, Social Security Number and date of birth
- A clear statement of your intent to revoke your AUTHORIZATION,
- The date of your request, and
- Your signature.

The AUTHORIZATION is requested by Harvey Shubert, Ph.D. for its own use/disclosure of your protected health care information. (Minimum necessary standards apply.)

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Harvey Shubert, Ph.D. reserves the right to refuse service. A copy of the signed AUTHORIZATION will be provided to you at your request.

**MISSED APPOINTMENTS** Unlike some other medical or paramedical professionals who operate on more flexible and inexact schedules, your counselor commits a specific time period, usually 45-55 minute sessions, to each patient. It is important that you appreciate the fact that this block of time has been set aside for you. Our schedules are usually crowded. Your canceling or rescheduling your appointment without sufficient notice often means the loss of an hour of therapy, and it is difficult to reassign the hour to someone else on short notice. A charge may be made for any appointment not canceled 24 hours in advance.

**PAYING YOUR BILL** We accept insurance payments but you are responsible for any balance on the account. Cash accounts or insurance co-payments are due at the time of service. If we are to submit for reimbursement for your insurance carrier, it is your responsibility to provide us with the proper forms and necessary signatures. New claim forms may be needed at the beginning of each calendar year.

**OFFICE HOURS** Business hours are 8:00 am to 12 noon and 2:00 to 5:00 pm. Monday through Friday. If you telephone the office at other than those times listed or when the therapist is in session or out of the office, an answering machine will record your message and we will return your call as quickly as possible. You may also use the answering machine to advise us if you need to cancel an appointment. Our after hour Urgent Care number is the Maricopa Crisis Center 24 hour crisis line at (602)222-9444. Should you have a life-threatening emergency, we suggest that you call 911 or the 24 hours crisis line.

**CONTACTING HARVEY SHUBERT, PH.D.** If you have any questions or complaints about this Notice or you want to submit a written request (to our office in any of the previous sections of the Notice, please call (480) 507-7880 or write to us at:

Harvey Shubert, PH.D.

4115 E. Valley Auto Dr., Suite 208

Mesa, AZ 85206

Phone: 480-507-7880, Fax: 480-507-8013

Day number and message number 24 hours a-day (480) 507-7880