TANQUE VERDE PEDIATRICS

7507 East Tanque Verde Road, Tucson, AZ 85715 Phone: 520-722-2585 Fax: 520-722-1097
WWW.TANQUEVERDEPEDS.COM

MENTAL HEALTH NEW PATIENT PAPERWORK

Name of Patient Date of Birth Reminder phone #

SCHEDULING AND FEE STRUCTURES:

_____ I understand that Tanque Verde Pediatrics Mental Health Services provides SHORT TERM therapeutic services. I understand that this will have a maximum of 4-8 sessions.

_____ I understand that once I have used my allotted sessions (4-8 as determined by my therapist), I will need to take a 3-month break prior to rescheduling for another set of sessions.

_____ I understand that if it has been more than 3 months since my last visit, I will be charged for an assessment/evaluation session upon return to services. This will be a 60 min session.

_____ I understand that it is my responsibility to secure a mental health provider within the community to continue my care if necessary after these sessions have been used.

_____ I understand that this is considered a **bridge service**. If I have identified and scheduled an intake apt with a provider in the community that is several months away, I can ask my Tanque Verde Mental Health Therapist to continue therapy sessions until this date; as well as provide a summary to my new therapist once they have been identified on my ROI (Release of information).

_____ I understand that it is my responsibility to start seeking a community therapist concurrently from the first appointment with my TVP therapist due to limited resources available in the community.

_____ I understand that when I make a follow-up appointment, I will be financially responsible for the full session cost unless I cancel 48 hrs in advance.

_____ I understand that if I am more than 10 minutes late to my session, my therapist may elect to not see me and reschedule my appointment for a future date and time. If my therapist is able to accommodate my lateness to my appointment, I understand that this is case by case, and cannot be guaranteed every session. I also understand that I will be charged the full session amount.
_____ I understand that if my therapist is running late, they will do their best to give me my full session time. If this cannot happen, they will downcode the appointment to the appropriate level and I will be charged less. (I.e. if the therapist can only offer a 30 min session, I will only be charged $60).

_____ I understand that it is my responsibility to know when my scheduled appointment is. Tanque Verde will attempt to provide a reminder call or text, but I understand that this is a courtesy and will be responsible for attending my appointment even if I do not receive a reminder.

_____ I understand that Telehealth video sessions will only be offered on a case-by-case basis at the determination of my therapist. If I do elect for a Telehealth session, I agree to have a private, quiet space with reliable internet connection. This means I will not be driving in a car, sitting with friends, or any other distractions.

_____ I understand that same day apts for immediate crisis support/ conflict resolution are only available if my therapist has openings in their schedule. I also understand I will be charged a higher rate of $100 per 30 min.

_____ I understand that if I choose not to have sessions with my therapist for a time period of 3 months or more, or miss 2 or more sessions (either because of no show or a late cancellation); I will be considered terminated from care. Should I desire to start services again, I will need to have a new pt assessment unless determined otherwise by my therapist.

_____ I understand that payment is due at time of services and agree to pay all necessary charges. I understand that this is a Self-Pay module. If I am requesting a billing receipt to receive reimbursement from my insurance company, I will need to contact the Front Desk or Billing Dept. Please see Fee schedule below:

Service	**Charge**	**Time**
No-Show/Late Cancellation Fee	The cost of scheduled service	
New patient evaluation	$175.00	60 minutes
Psychotherapy	$75.00	45 minutes
Psychotherapy	$60.00	30 minutes
Crisis Counseling	$100.00	30 minutes
Post-Partum Depression	$75.00	45 minutes
Group Therapy	$50.00	60 minutes
Family Therapy	$150.00	60 minutes

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: MENTAL HEALTH

With my consent, Tanque Verde Pediatrics, P.C. May disclose and/or obtain information from any doctors **within** Tanque Verde Pediatrics Practice participating in my care with Tanque Verde Pediatrics Mental Health Provider(s) assigned to my care and treatment.

The purpose of the disclosure(s) is in connection with mental health treatment, payment, or healthcare operations.

If the purpose is other than as specified above, please specify:_____

Name of Patient

Signature of Patient/Client Date

Signature of Parent, Guardian, or Personal Representative Date

With my consent, I also authorize Tanque Verde Pediatrics Mental Health Provider(s) to disclose and/or obtain the following information from the **following organizations:**

1. School Provider (May include teacher, counselor, IEP committee, etc):
   __ All relevant information needed to facilitate in my care at the discretion of involved professionals
   OR:
   __ Assessments and/or Evaluations
   __ Diagnosis
   __ Treatment Plan/or Summary
   __ Current Treatment Update
   __ Behavior Observations
   __ Educational Information
   __ Medication Management
   __ Presence/Participation in Treatment
   __ Termination/Transfer Summary
   __ Demographic Information
   __ Psychotherapy notes
   __ Other_____

2. Outside Mental Health Provider(s), Specialists, and or any Needed Entity (i.e. Psychiatrist, Counselor, Therapist, IOP or PHP treatment, Rehab, Group Therapies, Dietician, Daycare, sports coach, physical therapist, etc.)
   PLEASE SPECIFY PERSONS REQUESTED:

   Name:_____ Phone #_____ Email:_____

   Name:_____ Phone #_____ Email:_____

   Name:_____ Phone #_____ Email:_____

   __ All revenant information needed to facilitate in my care at the discretion of involved professionals
   OR:
   __ Assessments and/or Evaluations
   __ Diagnosis
   __ Treatment Plan/or Summary
   __ Current Treatment Update
   __ Behavior Observations
   __ Educational Information
   __ Medication Management
   __ Presence/Participation in Treatment
   __ Termination/Transfer Summary
   __ Demographic Information
   __ Psychotherapy notes
   __ Other_____

The purpose of the disclosure(s) is to coordinate with mental health treatment, payment, or healthcare operations.
If the purpose is other than as specified above, please specify:_____

I understand I have the right to revoke this authorization by submitting a request in writing to Tanque Verde Pediatrics. I further understand that a revocation of authorization is only effective after notification of receipt. This authorization **does not expire** unless documented below:
Date of Authorization Revocation: __/__/____

Disclosure may take place in any format deemed appropriate including but not limited to: verbally, paper, or electronic.

Name of Patient

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

CONFIDENTIALITY AND MANDATED REPORTER INFORMATION:

_____ I understand that what is said in session is confidential and will not be disclosed to unnecessary parties. This includes from parents or guardians if they are not present in the room.

_____ I understand that there are limits to this confidentiality. Times when my therapist may have to break this confidentiality include:

- If I have thoughts or have been hurting myself including typical self harm (cutting, burning, hitting, holding breath, drug usage, etc).
- If I have active suicidal thoughts or plans. If I have a concrete plan, my therapist will require me to create and sign a safety plan prior to leaving the session and all parties identified on the safety plan will be notified. If I cannot agree to safety, my therapist will call 911 to provide adequate supervision for safety.
- If I have disclosed any abuse that I have received or have done to another. This includes but is not limited to: physical, emotional, verbal, and sexual abuse. As a state mandated reporter, this is nonnegotiable on my part. Child Protective Services will be notified. Whether an investigation is started is up to THEIR department policies and procedures.
- If I have disclosed any neglect including but not limited to: daily needs (food, shelter, bathing, etc), attendance at school, medical neglect, and or having been put in dangerous situations (firearms that are not properly secured, witnessing drug deals, prostitution, and/or other situations that are considered child abuse or neglect by state statute).

OTHER POLICIES TO BE AWARE OF:

_____ I understand that my therapist will not accept or ask to "befriend" me on any social media platform. This is to ensure confidentiality and keep appropriate boundaries.

_____ I understand that it is likely that I will run into my therapist in the community or in various social groups (including social media groups we may share). My therapist will not acknowledge me in order to keep my confidentiality. I may choose to say hello and engage in conversation, but my therapist will never initiate this contact. My therapist will never refer to me as a client in the community. My therapist will respect my requests and boundaries and I will do the same for them.

_____ I recognize that therapy is HARD WORK. In the process of working through emotions, feelings, thoughts, and situations, I may feel worse or more upset. I understand that this is part of the process and will alert my therapist of changing or frustrating situations, emotions, and thoughts.

_____ I understand that my therapist can only work as hard as I am willing to do so; as I am the one responsible for the change. I also understand that any homework my therapist suggests will enhance my wellbeing and help to use what we have learned in session into my everyday life. I understand that if I choose not to do the homework, I may be slowing down my progress.

_____ I understand that my relationship with my therapist is just that, a relationship. It will have ups and downs, and times of connection and frustration. I agree to voice to my therapist anytime I do not feel connected, validated, offended, misunderstood, or any other situation that I feel is harming my ability to progress. My therapist will also bring to my attention anytime they feel the same. This not only will help my progress, but teaches and models appropriate ways to handle conflict and relationship issues. I can then use what I learn from this experience and the tools explored in my own personal life.

_____ I understand that I am expected to be an ACTIVE participant in my treatment including: my goals, direction each therapy session takes, and treatment planning. My therapist will do their best to make sure we stay to the course of treatment we have elected and in voicing their professional experience and opinion in diagnosing, referring to other levels of treatment, and treatment goals.

Name of Patient

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date