

**CLIENT RECORD**

ADMINISTRATIVE (to be completed prior to first session)

Client: \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Work Telephone: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Sex: Male  Female  Subscriber social security#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer/School: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Policy number: \_\_\_\_\_ Group number \_\_\_\_\_  
Married  Single  Divorced  Widowed   
Emergency Contact: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Name of primary insured: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Soc num. of primary insured \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Primary insured Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relevant medical conditions (history, current condition, changes in condition):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications (dosage, dates of initial prescriptions, name of prescribing professional):  
\_\_\_\_\_  
\_\_\_\_\_

Allergies/adverse reactions to treatment:  
\_\_\_\_\_  
\_\_\_\_\_

Primary care physician Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_

Reason for seeking counseling to day (include any prior history of counseling for mental health, alcohol or Other drug problems):  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Client's or legal guardian's signature Date

# Tucson Psychotherapy, LLC

## Authorization and Consent For Treatment

CHECK AS APPLICABLE: GROUP    INDIVIDUAL    FAMILY

Having been fully informed of the purpose and possible outcomes we/I give permission for the following to people to participate:

\_\_\_\_\_

We I understand that normal fee for this service is \$ \_\_\_\_\_ for \_\_\_\_\_ and we agree to pay \$ \_\_\_\_\_ at the time services are delivered. We understand the fee we/I pay may represent a co-payment if we have coverage. We agree to pay all fees left unpaid by our insurance-company after 90 days. Clients are responsible for coordinating their benefits from their insurance company. Any fees unpaid after 30 days will be charged 1.5% monthly interest. Any fees left unpaid after 90 days will go to collection and the client are charged for collection fees. There is a \$35 charge for any returned checks.

Cancelled appointments require at least 24 hours notice will be billed a \$45 broken appointment fee. This is because the time you schedule is reserved to provide services to you. Less than 24 hours is not enough time to schedule services for another client. Therefore, this agency incurs a financial loss if you fail to show, or give adequate time to change a scheduled appointment. For all non paying clients, three broken appointments will result in termination of services.

Tucson Psychotherapy, LLC, does not provide crisis services. If you are having a crisis please call a 24 hour crisis hotline such as **Southern Arizona mental health at 622-6000** or **Help on Call at 323-9373**. If you are not successful in getting help call 911 for assistance.

Everything said in therapy is confidential. However threats to hurt yourself or another person, or statements indicating physical or sexual abuse to a child or vulnerable individual are not protected under the confidentiality rule and that such abuse will be reported.

My signature below indicates that I have read and agree to abide by the above information. I give my consent for treatment. I acknowledge that I am the responsible party/custodian of the client and can legally authorize treatment. I have access to Tucson Psychotherapy, LLC's notice of privacy practices. I authorize the release the release of any of my medical, psychiatric or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefit to the clinician for services rendered. I fully understand that if my insurance denies payment for any services defined as a non-covered service, I will be responsible for any amount due.

\_\_\_\_\_

*Print*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Client or Legal guardian Signature      Date*

**Ky S Resh, MSW, LCSW  
1601 North Tucson Blvd. #36  
Fax & phone 520 320 9996  
chisresh@msn.com**

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I, \_\_\_\_\_  
(Print Full Name) (Date of Birth)  
Hereby authorize the release of my health information

<b>From:</b> Name: _____ Address: _____ City, State, Zip: _____
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<b>To:</b> Name: _____ Address: _____ City, State, Zip: _____
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**I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.**

**Purpose of disclosure:**

\_\_\_\_\_  
**Information requested:**

\_\_\_\_\_  
**I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 90 days after the date signed. The requestor should not re-disclose my medical record to another party without further written consent.**

**I will not hold Ky S Resh liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Ky S. Resh for clarification of the information therein.**

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**(Patient or Legal Representative)**

**Date:** \_\_\_\_\_ **Witness:** \_\_\_\_\_

## Psychotherapy Process Note

***This document cannot be released without separate written authorization***

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**Theme:** First session/expectations/responsibilities/obligations of both parties

**NAME:**

**Date:**

**Were there phone contacts since last sessions** No  Yes

**Describe:**

**D:** Met with Ct for the first time for one hour and explained the importance of; Ct's signed statement of understanding.

- Fact sheet
- Identifying information
- Limits of Confidentiality and consent to treat
- Permission to treat
- How we will work together
- Authorization to release and receive information
- Limits of confidentiality
- Fee agreement

Thx also explained about the therapeutic process, having realistic expectations and the need for cooperation in terms of finishing home work. Thx also discussed expectations of client for therapy, and explained that thx attends a monthly consultation group and may discuss their case but not divulge their name or place of work and will maintain identifying information as strictly confidential. Also explained that thx has epilepsy and those implications.

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Ky S. Resh, MSW, LCSW

*Treatment plan*

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1.  *Assessment*
2.  Ascertain presenting problems
3.  Inquire regarding all symptoms (*on a regular basis*)
4.  Assess for cognitive, behavioral, and interpersonal deficits
5.  Assess impairment in social, educational and occupational functioning
6.  Administer standard bdi (*intermittently*)
7.  Evaluate for co-morbid conditions
8.  Evaluate for suicidal risk (*on a regular basis*)
9.  Evaluate substance use; evaluate need for counseling or detoxification if patient has substance abuse or dependence
10.  Assess need for medication (*will continue to discuss*)
11.  *Homework*

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Ky S. Resh, MSW, LCS

## Adult Treatment Plan

- 1. Educate about the effect of childhood events on the brain**  
increase understanding about the physical aspect of emotion and various behavioral strategies to manage them. Based on this understanding of the body / mind as part of the emotional system the client is asked to begin a regular exercise program. Get a massage on regular basis to help with tension.
  
- 2. Educate about errors of cognition.** Understand the effects of Invalidating the positive, Scanning for negative information about the self, heaven's rewards fallacy.
  
- 3. Increase awareness of patterned emotional responses.**  
Increase awareness of feelings as they occur at a ratio of three out five times during the week. Develop the habit of monitoring feelings through non judgmental mindfulness practice from moment to moment.
  
- 4. Learn to regulate emotional responses.**  
Improve ability to handle feelings and practice recovering quickly from upsets and distress through using distress tolerance and self soothing techniques.
  
- 5. Empathic responding to self.** Look at self in context. Practice recognizing and identifying, context of emotions in order to accept self as allowed to have feelings. "This is what I am feeling right and that's ok."
  
- 6. Practice setting limits and personal boundaries with others.** Begin to recognize personal needs and desires.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date