Linda Griffith, LCSW, DCSW
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Welcome! I'm so glad you've decided to experience Emotional Transformation Therapy (ETT™) I hope you will find it to be as miraculous as I first did (and still do). I've prepared this packet so we needn't waste time on federally required paperwork and important background. If you have any questions about any part of the forms, please call me. Otherwise, be sure to answer all questions, scan and email it back to me 2 days before your first session and bring the completed paper form with you (as well as keeping a copy for yourself).

IMPORTANT: ***IF EVER IN A MENTAL HEALTH CRISIS CALL 911 or go to the nearest hospital emergency room. I do not provide emergency treatment, but as your psychotherapist, I will follow emergency services with therapy for you and/or your family.***

QUALIFICATIONS: I received my Master of Social Work degree from the University of Nebraska in 1979 with a specialties in medical and gerontological social work; joined the Academy of Certified Social Workers in 1982; awarded Diplomate in Clinical Social Work status, a distinguishing credential of the National Association of Social Workers, in 1987; continuously licensed as an LSW to practice independently in Pennsylvania since 1989; licensed as an LCSW in Arizona since 2016. Additional certifications and specialties include: Human/Companion Animal Bond; Death & Dying; Rankian/Functional Modality; Ethical Practice Education for Social Workers; Integration of Spirituality and Synchronous Guidance; Wright Protocol for Repair and Reattachment Grief Therapy (afterlife contact); and Emotional Transformation Therapy (ETT™).

As an ETT™ specialist, I am qualified to treat clients quickly and effectively with neurologically-based ETT™ techniques in all areas of behavioral health. Following, however, are areas in which I choose *not to* accept clients due to the acute nature of these issues which I feel deserve the best possible care by therapists concentrating in these fields:

Individuals Under the Age of 18 • Individuals Addicted/Abusing Alcohol, Drugs or Other Substances (excluding nicotine) • Individuals in Active States of Psychosis or Crisis • Individuals at Risk for Violent or Explosive Behavior and/or Self- Harm • Acute Life-Threatening Eating Disorders • Individuals Requiring Documentation or Testimony Related to Disability, Workman's Compensation or Other Third Party / Litigation Claims (excluding standard health insurance requirements).

Do you fall into any of those categories? _____No _____Yes If you answered "Yes," would you like me to assist you in finding a therapist better suited to provide care? If so, please call me at 520-333-2193. If you are uncertain about whether or not you might be in one of the above categories, let's talk it over on the phone prior to your first appointment. Please call before going any further with the forms.

ABOUT PRINTING CLEARLY.....both federal law and standards of professional practice *require* a psychotherapist to obtain certain background information to accurately diagnose problem(s). If your answers on the form that follows cannot be read easily and clearly, a record audit can result in the revocation of insurance coverage or ethical concerns regarding the therapist's practice. Therefore, you MUST PRINT CLEARLY OR IT WLL BE NECESSARY TO REWRITE YOUR ANSWERS DURING YOUR SESSION TIME so I can *easily* read them. :-) THANKS!

First Name: _____Middle Initial____Last Name_____Date of Birth:_____

Age:_____Sex: □M □F □Other _____Marital Status:_____Mobile #:_____Other #:_____

Address: _____City:_____State:____Zip_____- _____

Email Address: _____Spouse/Partner's Name:_____Together how long_____

Date of Birth_____Age:_____Sex: □M □F □Other_____ Mobile #_____Other #_____

EMERGENCY CONTACT:_____ Relationship_____Phone:_____State:____

What has prompted you to seek help:

Previous Mental Health Treatment

1) Year_____□In-Patient □Out-Patient How long:_____
Reason:_____Diagnosis_____
Dr/Therapist:_____City_____State_____ Your experience: □positive □neutral □negative

2)Year_____□In-Patient □Out-Patient How long:_____
Reason:_____Diagnosis_____
Dr/Therapist:_____City_____State_____ Your experience: □positive □neutral □negative

3)Year_____□In-Patient □Out-Patient How long:_____
Reason:_____Diagnosis_____
Dr/Therapist:_____City_____State_____ Your experience: □positive □neutral □negative

Current Medications for Emotional/Mental/Sleep Problems:

Medication	**Dosage**	**Reason**	**Date Started**	**Describe Any Side Effects**	**Prescribing Professional**
1)					
2)					
3)					
4)					
5)					
6)					

Physical Health: Would you describe your current physical health as ☐poor ☐fair ☐good ☐very good ☐excellent
Height: Weight: Primary Physician: Phone Number: Last physical exam:

Physical Conditions (including illness, surgery, accident, allergy, etc starting with earliest):	**Date of Onset**	**Do Your Symptoms Impact: work**	**school**	**relationships**	**money management**	**social activity**
σ Heart disease	_____	**σ**	**σ**	**σ**	**σ**	**σ**
σ Diabetes	_____	**σ**	**σ**	**σ**	**σ**	**σ**
σ Alzheimer's or dementia	_____	**σ**	**σ**	**σ**	**σ**	**σ**
σ Cancer	_____	**σ**	**σ**	**σ**	**σ**	**σ**
σ Arthritis	_____	**σ**	**σ**	**σ**	**σ**	**σ**
σ Chronic Pain in_____	_____	**σ**	**σ**	**σ**	**σ**	**σ**
σ COPD/other lung condition	_____	**σ**	**σ**	**σ**	**σ**	**σ**
σ Thyroid disease	_____	**σ**	**σ**	**σ**	**σ**	**σ**
σ Other (describe below)						
a)_____	_____	**σ**	**σ**	**σ**	**σ**	**σ**
b)_____	_____	**σ**	**σ**	**σ**	**σ**	**σ**
c)_____	_____	**σ**	**σ**	**σ**	**σ**	**σ**
d)_____	_____	**σ**	**σ**	**σ**	**σ**	**σ**
e)_____	_____	**σ**	**σ**	**σ**	**σ**	**σ**
f)_____	_____	**σ**	**σ**	**σ**	**σ**	**σ**

Current Medications for Physical Conditions	**Dosage**	**Reason**	**Date Started**	**Describe Any Side Effects**	**Prescribing Professional**
a)					
b)					
c)					
d)					
e)					
f)					

Other Health Care Providers **Type** **How Long In Treatment**

a)_____

b)_____

c)_____

Nutritional Supplements, Herbs, Other Alternative Medications:

Physical Exercise Type:_____ Minutes Per Day:_____Days Per Week:_____

Any Up-Coming Medical Tests, Treatments, Concerns:

Cultural Considerations:
Are you or your family experiencing threats, discrimination or other problems related to your racial, religious or ethnic background (including language difficulties)? ☐No ☐Yes explain:

Your Strengths: What are THREE things about you that get you through hard times?

1)_____
2)_____
3)_____

Please give details and dates if you have ever:

σ Been physically hurt or threatened by another?_____

σ Been raped or sexually touched against your will?_____

σ Lived through a disaster?_____

σ Been a combat veteran OR exposed to an act of terrorism?_____

σ Been in a severe accident or close to death for any cause?_____

σ Witnessed death/violence/threat of violence to someone else?_____

σ Been the victim of a crime?_____

σ Felt your alcohol or drug use has ever contributed to a problem in your life?_____

σ Been in an emotionally abusive marital or partner relationship?_____

Present Living Arrangement:_____

Children Names and Ages:_____

Pet Names, Species, Ages:_____

Current Employment/Military Service:_____Hours per week:_____

Primary Profession or Occupation throughout your life:_____Employed regularly ☐Yes ☐ No explain:

Education: completed σ junior high σ high school σ undergraduate school (major:_____) σ graduate school (degree: _____)

post-graduate (degree: _____) other specialized/technical/ occupational training:_____

Did you receive any special tutoring, counseling or special assistance during your schooling? ☐No ☐Yes explain:_____

PARENTS AND FAMILY

Where did you growing-up:_____Who raised you:_____ How was the relationship between your parents:

If your parents were married, was there any history of separations or divorce? ☐No ☐Yes explain:

Father

Name: _____Current age:_____(or age at death:_____Cause: _____Year:_____)

Describe your father:

Highest educational level:_____Occupation: _____Alcohol or drug abuse? ☐No ☐Yes explain:

Legal problems: ☐No ☐Yes explain:_____ Emotional problems: ☐No ☐Yes explain:

Primary method of discipline: _____

Mother

Name: _____Current age:_____(or age at death:_____Cause: _____Year:_____)

Describe your mother:

Highest educational level:_____Occupation: _____Alcohol or drug abuse? ☐No ☐Yes explain:

Legal problems: ☐No ☐Yes explain:_____ Emotional problems: ☐No ☐Yes explain:

Primary method of discipline:

Where do your parents currently reside: _____ Did either parent abuse or neglect you? ☐No ☐Yes explain::

If you could change anything about your parents or family, what would it be?

Stepparent
Name: _____Current age:_____(or age at death:_____Cause: _____Year:_____)
Describe your stepparent:

Highest educational level:_____Occupation: _____Alcohol or drug abuse? ☐No ☐Yes explain:

Legal problems: ☐No ☐Yes explain:_____ Emotional problems: ☐No ☐Yes explain:

Primary method of discipline: _____

Sibling's Name (oldest first)	older/younger than you	age or year of death	type of childhood relationship	type of relationship now
1)	☐older ☐younger			
2)	☐older ☐younger			
3)	☐older ☐younger			
4)	☐older ☐younger			
5)	☐older ☐younger			
6)	☐older ☐younger			

PERSONAL HISTORY AND HELPERS (Significant events in your life, eg: losses, moves, injuries, honors, awakenings, traumas)

AND name/relationship of any living person/animal/angel/spirit in afterlife who might have been there in a special, loving way:

Ages birth to 5 events:
(Helper:)

Ages 6-10 events:
(Helper:)

Ages 11-15 events:
(Helper:)

Ages 16-20 events:
(Helper:)

Ages 21-30 events:
(Helper:)

Ages 31-present events:
(Helper:)

Previous Marriages/Relationships Age first sexual contact: Age first romantic sexual relationship: Age first LGBTQ experience:
Sexually active now? □No □Yes (Do you practice safe sex? □No □Yes) Is fidelity presently an issue in your relationship? □No □Yes

Primary Relationships Name	Year Started	Year Ended	Describe Relationship
1)			
2)			
3)			

Who is your best friend:_____For how long:_____Why:_____

Armed Services Experience

Were you in the armed services? □Yes □No (If no, please go to next section) Branch:_____ Length of time served:_____

Type of work: _____ Highest rank achieved:_____ Type of discharge:_____

Any awards/commendations received? ☐No ☐Yes (Describe:) Any disciplinary action? ☐No ☐Yes (Describe):

Feelings/thoughts about time in service?

Financial Situation: ☐terrible ☐fair ☐good ☐very good How much debt (other than mortgage and car payments):_____
Have you ever filed for bankruptcy? ☐No ☐Yes (year:) Are you currently able to pay bills and provide essentials? ☐No ☐Yes
Do you gamble? ☐No ☐Yes (Describe:)

Substance Abuse: How often do you consume alcoholic beverages: _____☐per day ☐per week ☐per month ☐per year
How many times have you been drunk in the last year: _____? In last five years:_____?Ever experience blackouts from alcohol? ☐No ☐Yes
Anyone ever express concern about your drinking? ☐No ☐Yes Have you ever received a DUI (Driving Under the Influence)? ☐No ☐Yes
Have you ever used ☐Marijuana ☐Cocaine ☐LSD ☐Heroin ☐Speed ☐Barbiturates ☐Prescription drugs recreationally
If any checked, at what age did you start:_____How much did you use? ☐a little ☐fair amount ☐a lot Did you ever sell drugs? ☐No ☐Yes
Have you ever attended AA or substance abuse treatment? ☐No ☐Yes Do you smoke/inhale tobacco? ☐No ☐Yes (# packs or equivalent per day:_____) Describe your present eating habits, type of food, attention to nutrition, eating at home or out:

Legal or Criminal History: Have you ever been detained or arrested? ☐No ☐Yes (Explain):
Have you ever been charged with a crime? ☐No ☐Yes (Explain):
Have you ever been convicted? ☐No ☐Yes (Explain):
Were you ever in jail or prison? ☐No ☐Yes (Explain):
Has your driver's license ever been suspended? ☐No ☐Yes (Explain):

Religious and Spiritual Beliefs Was religion a significant factor (positive or negative) of your childhood experience? ☐No ☐Yes (Explain):

Have you ever felt, seen or heard the presence of a person or pet who has died? ☐No ☐Yes (Who):
Have you ever had a near-death experience? ☐No ☐Yes (Age at the time: Explain):
What, if any, are your present religious or spiritual beliefs?
With whom, if anyone, do you share your religious or spiritual feelings?

Leisure Activity: Do you have hobbies or leisure interests (Describe):
How many hours of t.v. do you watch per day?_____What are your favorite programs?
Do you enjoy music? ☐No ☐Yes, what kinds of music do you most enjoy? If you perform music, elaborate:
Do you enjoy reading or writing? ☐No ☐Yes, what kinds of books/magazines do you most enjoy:

What is your style/purpose in writing:
How many hours per day do you spend accessing internet sites other than for work? _____hours
Web sites visited most: σ social media σ dating σ pornography σ games σ news σ education
Other Information About You Important for Me To Know:

What is your overall level of distress in daily living: (least) 1 2 3 4 5 6 7 8 9 10 (most) Date of first appointment:_____

Informed Consent for Emotional Transformation Therapy Treatment

I authorize and request that Linda Griffith, LCSW DCSW, through her qualifying training and experience as an Emotional Transformation Therapy (ETT™) specialist, utilize color resonance as well as traditional diagnostic procedures and/or treatments within a therapeutic relationship which now, or during the course of my care as a patient, are advisable based on my participation in defining, reviewing and revising (as needed) the objectives for my treatment (Plan of Care). I understand that the purpose of these procedures is to assist me in meeting my treatment goals and will be explained to me upon my request. While ETT™ specifically discourages emotional suffering through the reliving of trauma, I understand that the healing process sometimes involves provoking tolerable levels of discomfort before relief is achieved.

I understand that at all times I have the right to refuse or withdraw consent to treatment following consideration of any consequences that I may experience as a result, of which Linda Griffith, LCSW, DCSW will advise me.

I further consent to achieving wellness quickly which carries with it the risk of redefining my life in ways that best serve me emotionally, mentally, physically and spiritually and might be unsettling to others. I understand that the greatest risk associated with ETT™ treatment is that the speed and ease with which I can become well might suddenly alter my view of myself and reality in significant ways.....***INITIALS_____***

Informed Consent for Phototherapy Treatment

Although light stimulation devices used here are generally safe, I understand the following information about potential hazards may exist and no claim about guarantees of effectiveness is made. Light stimulation devices are not recognized as medical devices and all participation with them is strictly voluntary and experimental. Although some research findings are known, there is presently not enough for it to be recognized as standard treatment.

____Yes ____No Do you have a history of photosensitive seizures?
____Yes ____No Do you have a life-threatening illness?
____Yes ____No Are you having suicidal thoughts?
____Yes ____No Are you taking medications that are known to have photosensitive side effects? If so, check with your physician to determine if these side effects are signi ficant enough to recommend avoiding low brightness (40 watts) light stimulation into the eyes.
____Yes ____No Do you feel prone to violence or homicide?
____Yes ____No Do you have medical conditions that are important to disclose here? If so, what?_____

Delayed emotional and physical reactions from the exposure to light stimulation may occur.
Bright blue light has been found to be potentially hazardous to the retina. No claims are made for sexual enhancement. I understand and consent to participate in phototherapy. ….....***INITIALS_____***

Agreement Regarding Payment of Fees

I understand that full payment of fees is expected at the time services are rendered. I understand that I am responsible for all charges, and I agree to pay all charges, including any for services not covered by my insurance. Unpaid fees may result in the reporting of my delinquent account to a collection agency and/or in a court judgement. If a co-payment is required, it is expected to be paid at the time of each visit. If the co-payment is unknown, you will be billed for the amount at a later date with an explanation of benefits from your insurance company.

Initial Consultation	90 minutes (discounted 1st session rate)	$135.00
Individual Therapy Sessions	50 minutes	$100.00
	60 minutes	$120.00
	90 minutes (by necessity or request)	$180.00
Afterlife Contact (Wright Protocol)	Up to 5 hours (including follow-up session)	$500.00
Universal Mind Contact (Samadhi Protocol)	Up to 5 hours (including follow-up session)	$500.00
Telephone or Correspondence Consult	Under 10 minutes	No charge
	Beyond 10 minutes (cumulative per month)	$120.00 per hr.
Travel for Home/Institutional Visit	Actual travel time plus 54 cents per mile	$120.00 per hr.
Records Review / Form Completion		$120.00 per hr.
Copy of Records Processing Fee		$35.00 + postage
Missed Appointment**	If less than 36 hours notice	$120.00
Insufficient Funds Check Fee		$50.00

**Many are often waiting for openings to become clients and, thus, a missed appointment not only is costly to me, but emotionally costly to whomever might have been able to get help in that time slot. Thank you for understanding this. Payment for a missed appointment is due at the next session.

I have read, understand and agree to the policies and fee schedule stated above.....***INITIALS_____***

If Planning to Pay by Credit Card

Credit Card Full Name: _____

Credit Card Number: _____

Expiration Date: _____/_____ Security Code (3 Digits for Visa, 4 Digits for AMEX): _____

Authorization to Assign Benefits

I irrevocably assign to Linda Griffith, LCSW, DCSW all payments for medical/psychological services rendered and all major medical benefits..***INITIALS_____***

Notice and Acknowledgement of Privacy Practices

The HIPPA form you are asked to sign below assures that written and spoken material from any and all sessions and psychological testing, is held strictly confidential and is protected, unless you give written permission to release all or part of it to a specified person or agency. Exceptions involve situations where the therapist is mandated to report suspicions of child or elder abuse and imminent danger to self or others, or your mental health record is used in your defense in litigation (see below). In addition, it must be understood that the therapist may consult with other professional associates or your referring primary care physician to ensure the highest quality of care. You may obtain a copy of your record by requesting it in writing and paying a $35. processing fee plus any postage applicable to delivery.

Exceptions

1. The patient authorizes release of information with his/her signature
2. The patient presents a physical danger to self
3. The patient presents a physical danger to others
4. Child/elder abuse or neglect is suspected

In the latter two cases, Linda Griffith, LCSW, DCSW is required by law to inform potential victims and legal authorities so that protective measures can be taken.

I have received a copy of the Notice of Privacy Practices (available for download at www.counselingtucson.com or in print by request).....***INITIALS_____***

HIPAA Privacy Authorization Form Authorization for Use or Disclosure of Protected Health Information

1. *Authorization*

I authorize Linda Griffith, LCSW, DCSW (healthcare provider) to use and disclose the protected health information described below to:

- to my insurance carrier(s) and/or managed care company concerning this illness and treatment
- to personnel hired or contracted by Linda Griffith, LCSW, DCSW to assist in the evaluation of benefits, billing, processing of insurance claims or other administrative tasks
- ETT™ (Emotional Transformation Therapy) Master Teachers Consultants for purposes of professional consultation regarding advanced and developing techniques that may benefit my treatment
- other qualified medical and psychotherapeutic professionals with whom consultation is deemed by Linda Griffith, LCSW, DCSW to be beneficial or necessary

2. *Effective Period*

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

3. *Extent of Authorization*

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4.This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until I revoke it in writing, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization except the extent that a refusal to release information to insurance companies and personnel responsible for processing claims may result in unpaid claims for which I am then financially responsible.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.....***INITIALS_____***

Electronic Communication Acknowledgement and Agreement

I understand the risks associated the communication of e-mail as set forth in this consent form.

Despite the risks associated with e-mail. I agree that Linda Griffith, LCSW, DCSW may use e-mail to facilitate communications with and about me. I understand that

disclosures regarding my treatment and diagnosis may be made to not only me but also internally within the Practice's office or to appropriate third parties for services such as billing and/or treatment. Linda Griffith, LCSW, DCSW may call my phone number(s) and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, such as appointment reminders, insurance items and any calls pertaining to my clinical care. Linda Griffith, LCSW, DCSW may mail to my home or other alternative location any items that assist the practice in carrying out treatment, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." (Please do not text any personal, medical or clinical information. Texting is not a secure method of communicating. In the interest of maintaining your privacy, please utilize texting for scheduling purposes only).....***INITIALS*****_____**

Appeals and Grievances

I understand that I have a right to submit a complaint or grievance and risk nothing to exercise that right. I understand that to submit a complaint or grievance, I may contact the following:

Arizona Board of Behavioral Health Examiners, 3443 N Central Ave, #1700, Phoenix, AZ 85012

Your Signature (or personal representative's signature):_____Date_____

Printed name of patient or personal representative:_____ _____

Relationship to patient_____

I want to thank you for persevering with the questions. It truly does make a difference to have this done so we can get right to the most important concerns that you have when we meet. I'm looking forward to that!

PLEASE SCAN AND RETURN 48 HOURS BEFORE YOUR FIRST APPOINTMENT TO LG@COUNSELINGTUCSON.COM