Center for Child and Family Counseling, PLLC
1081 Dove Run Rd., Ste. 201 A, Lexington, KY 40502 Phone 859-554-6028
Website: www.yourkycounselor.com

Hello.

It is with great pleasure that we welcome you to our clinical practice. Our hope is to serve you and/or your family to work toward the best possible outcome.

You have several rights as a client. These include the right to know fees, ask questions and to end services at any time. The paper work which follows will also inform you of the limits of confidentiality and how your personal health information may be used with insurance companies.

The following paperwork must be completed in its entirety for the assessment and following counseling sessions to take place. Your information is confidential within the limits described on the following pages. Keeping your privacy is something we take very seriously. If you need assistance completing some of the questions, we will gladly assist you at our first session.

Please have a seat in the waiting area. Although we are expecting you, we may be with another client and will be with you as soon as possible.

Again, thank you kindly for choosing our practice. We look forward to providing counseling services to help you. .

If you are interested in counseling, please read and complete the information in this packet.

1. Client and Intake information.
2. Notice of Privacy Practices Handout is available.
3. Please note that if more space is needed turn page over and continue there.

This Information is required before services are provided.

Center for Child and Family Counseling, PLLC

Client and Intake Information

Full Name _____ SS# _____DOB _____

Address _____City_____ Zip_____

Home Phone Number _____ Cell _____Work _____

Email Address (to send reminder of appointments: _____

Is it OK to leave a message at the numbers listed? YES ☐ NO ☐

Emergency Contact _____Emergency number _____

Parents Name, if a Child/ Adolescent _____

Insurance Subscriber (individual whose insurance is providing the coverage) _____

Subscriber's DOB _____ Insurance Company Name _____

Subscriber's ID# _____ Subscriber's Group # _____

Subscribers Employer _____

(Your mental health benefits may be administered by a different company than your card reflects)

You agree to allow me to file/process for payment through your insurance on your behalf? YES ☐ NO ☐

*****It is your responsibility to contact your insurance company for authorization prior to the initial visit. ******

Do you have a deductible plan or HSA? YES ☐ NO ☐ Amount _____

Has the individual deductible been met for the client seeking services? YES☐ NO ☐
If not, you will be charged the full contracted rate until the deductible is until met (usually between $55-80).

Do you a co-payment or co-insurance? YES ☐ NO ☐ Amount or percent? _____

Are your sessions limited or unlimited? YES ☐ NO ☐ _____ # of session per year, if limited.

Center for Child and Family Counseling, PLLC

Informed Consent & Permission for Treatment

Please review the information requested below. Your signature will indicate that you understand and accept the information contained in the Informed Consent Information and Permission for Treatment.

Counseling Services: Counseling or psychotherapy of any type has risks and benefits. Often counseling/psychotherapy involves addressing problems or issues you or your child(ren) have avoided for some time. The process of counseling/psychotherapy may heighten or increase symptoms or negative behaviors prior to feeling better or a consistent change in behavior is noted. It does not mean counseling/psychotherapy is not effective, and does mean that you or your child(ren) are working through the issues that brought you in to counseling/psychotherapy.

Confidentiality: This office and clinician follows strict State and Federal confidentiality and privacy practices. Your information, including your status as our client is kept strictly confidential. I respect your legal right to confidentiality and will protect your information with the proper care. Identifying information will not be released without your permission. All records will be maintained in a confidential manner. Consent forms will be required for the release of any information. State and Federal laws may require the release of information without written or verbal consent in the following specific situations: 1. Medical or Mental Health Emergencies 2. Clients become a danger to themselves (Suicidal thoughts/behaviors/attempts, severe depression, etc.) 3. Clients become a danger to others (Homicidal thoughts/behaviors/attempts). The person threatened and the police will be notified. 4. Any report or suspected child abuse or neglect (Physical or sexual). 5. Any report or suspected domestic violence. 6. A court order directing the release of information. 7. Any litigation or board complaint initiated by the client or family member related to treatment. 8. Any abuse of the elderly, or those with mental illness or who cannot care for themselves properly. 9. Couple/family therapy/group counseling has limits in confidentiality (a divorce or child custody proceedings) wherein one person in the counseling relationship may demands, court-order records.

It is important to remember that when one parent has residential custody and the other parent does not it is our policy to offer the non-residential parent the ability to come into the office to discuss any concerns they may have for their child(ren). Our role is treatment and it is important to meet as many individuals as possible that your child interacts with to best meet the needs of your child in treatment.

Request for Medical/Mental Health Records: A request for records will be made with 30-day written notice. The client may request one free copy of their record. The counselor may request the client meet to review the record, as needed. Any request by other parties (attorney, parents, medical professionals) will be charged at $0.35/page, and postage, if mailed. Since mental health records have an extra layer of confidentiality protection, some or all of the record may not be available for review. A child's mental health records requested or subpoenaed in case of divorce custody/timesharing case will be made available only to the Judge for an in-camera review to protect the child and parents in the case. If the counselor is court-ordered by a Judge to make the mental health record available during counselor testimony, no part of the record will be provided to the attorneys.

Court Ordered Testimony: If requested or required to testify in any case, the requesting party(ies) will be charged for preparation of the testimony, written or verbal correspondence with parties (attorney, or other professionals) at $100 per hour; copies of documents needed for court at $0.35/page; additional cost of travel time to and from the destination, time waiting to be called to testify, and parking fees as outlined in the Fees for Services document within this packet. This is NOT covered by your insurance coverage. A deposit of $500 is required upon request for this service.

Contact After Hours: If I need to reach my therapist after hours for something other than making an appointment I will call the office phone number and leave a message. If it is an emergency I will go to the nearest emergency room or call 911. If I need to reach my therapist between sessions by phone for a therapy session I will be charged at a rate of 25.00 per 15 minutes which may not be reimbursable by insurance.

I understand and agree to the limits of confidentiality, privacy practices, the aspects and all procedures, and as stated and give my permission for treatment as indicated above. I agree to hold Center for Child and Family Counseling, PLLC harmless for any loss, cost or damages sustained by my spouse, child or me. By signing this form, I hereby authorize Janet Vessels, M.S. LPCC or the staff of the Center for Child and Family Counseling, PLLC to assess, diagnose and treat mental health and/or substance abuse problems for myself, my family and or my child.

By signing this form, I agree to the information as indicated above. Any exceptions will be written in by the clinician and initialed.

_____ **Date** _____

Client Name-Print Please

_____

Client Signature

Center for Child and Family Counseling, PLLC

Explanation of Service Fees

Counseling is a fee-for service. Payment for services is due at the time of service delivery. Cash, check or credit cards and Health Savings/Spending Accounts (HAS's) are accepted forms of payment. We do NOT regularly send out statements for payments owed.

Insurance Billing: We will try to bill your insurance when authorized to do so. Any payments not made by your insurance provider will be your responsibility including, but not limited to: deductibles, co-pays, co-insurance and any fee not covered by your insurance provider. It is your responsibility to know your plan's deductibles/limits/copays. Please acquire this information prior to your appointment. If you do not know or have access to the information, the counselor may be able to access the information. However, it will impact the time spent completing the assessment or conducting counseling (you may be charged for the extra time).

We require payment at the time of service. If you have a deductible or co-pay, this payment is expected at the time of service.

If your insurance company requires a deductible, Center for Child and Family, PLLC must accept the contracted and discounted rate for the session, usually between $55-85.

If you have insurance, please understand that this is an agreement between you and your insurance company. ***If your insurance company requires an authorization for your visits, please make sure that you have obtained this authorization prior to your first appointment. If your insurance company denies your visits for any reason, you will be responsible for the full cash fee rate of each of these visits at the rate listed in this document.***

I consent to release any personal or clinical information required to process my claim to my insurance provider listed on the back of this form. I also authorize any payments made by my insurance company to be paid directly to Center for Child and Family Counseling, PLLC. This form will be considered a signature on file for all future insurance claims. This release will expire 1 year from the date of your last appointment.

The billing department will assist you in submitting your insurance forms and resolving any problems with payments. If, however, your insurance company does not pay the anticipated amount, you are still responsible for the total amount of the bill. Please be aware that insurance benefits quoted by your insurance company are not a guarantee of payment. Ultimately, it is your responsibility to know the benefits of your policy and any changes that may arise are your responsibility.

Non-payment for services: In the event your account is not paid within 90 days, whether you receive a bill from us, we will try to collect from you. If your balance exceeds $500, collection proceedings will be instituted at your expense. You understand this office will release my information to a third-party Credit agency to attempt to collect a debt. The information provided to the Credit agency will only be demographic information to collect this debt. If your account is sent to collections, you will be responsible for all costs of collections including reasonable collection agency fees, attorney fees, and court costs. Additional interest of 5% may be added to the bill if there remains a after 90 days. Interest on the balance compounds monthly.

Extended Sessions: Extra time during session (not covered by insurance). At times the need arises for extended sessions. People often report significant benefit from sessions lasting 1 1/2 hours. We are excited to offer these sessions as an added service to you. Insurance carriers often cover the first part of these sessions and the client is then responsible for the other half (Optum Behavioral Health does not pay for extended sessions without prior approval in special circumstances). Any session going over allotted scheduled time will be billed to client at $25/15-minute increments (See Fee Schedule for more details).

I have read and understand the above statements and agree to be bound by the terms in these policies. I have had the opportunity to ask questions about anything in this policy and have had my questions answered to my satisfaction.

By signing this form, I agree to the financial responsibility of payment for the services I receive at the costs indicated above. Any exceptions will be written in by the clinician and initialed.

_____ **Date** _____

Client Name-Print Please

_____

Client Signature

Center for Child and Family Counseling, PLLC

Fail to Keep Appointments and Late Cancel Policy

You are required to contact your Counselor if you are unable to keep your scheduled appointment, either by calling the office at (859) 554-6028 and leave a message, texting the counselor's number and leave a message or contacting the counselor through their email address provided to you at the initiation of counseling. It would be wise to attempt to contact them using two methods. Please note that contacting the office and leaving a voicemail may not guarantee the counselor receives the message in a timely manner. The voice mail messages left are time stamped, however the office telephone is not monitored 24 hours a day. Messages left may not be picked up in time to contact your counselor.

If you LATE CANCEL (less than 24-hours notice), an attempt to fill your appointment time will be made and you may not be charged if someone can take that time. Otherwise, you will be expected to pay the late cancel fee of $65.

In the instance, you DO NOT KEEP YOUR APPOINTMENT, you will be charged the full cash price for a regular individual appointment at $100 for a single session. If you have more than one scheduled appointment (for example, two or three scheduled appointments for different children), you will be charged for ALL sessions. Many people believe you are only charged your co-pay but this is inaccurate. Your insurance CANNOT be billed for your appointment, and that time cannot be given to anyone. Therefore, you owe the entire amount of $100/session.

If you have other appointments scheduled, those appointments will be canceled unless arrangements are made with your counselor. This allows the counselor to serve others who may be able to attend those appointments. If you late cancel or fail to keep your appointments more than twice in a row or three times during the course of treatment, services may be terminated so other people can receive services.

I have read and understand the above statements and agree to be bound by the terms in the Fail to Keep Appointment/Late Cancel policy. I have had the opportunity to ask questions and have had my questions answered to my satisfaction.

By signing this form, I agree to the financial responsibility of payment for the services I receive at the costs indicated above. Any exceptions will be written in by the clinician and initialed.

_____ **Date** _____

Client Name-Print Please

_____

Client Signature

Center for Child and Family Counseling, PLLC

Fees for Services

Services	Time/ Minutes	Cost	Insurance/Self Pay Rate, if known	Client Initials
Initial Intake	60	$150		
16 to 37-minute Individual session*	30	$75		
38 to 52-minute Individual session*	45	$100		
53+--minute Individual session*	53+	$150+		
(sessions which are over the insurance billable minutes will be charged $25/ 15 minutes to the client)**				
45-minute session with a family with or without client	45-60	$150		
Marriage / Couple Counseling	45-60	$150		
Other Fees Associated with Services Not Paid by Insurance				
"No Show" Fee		$100		
"Late Cancel" Fee (24 hours or less)		$65		
Return Check Fee		$30		
Copies of Records		$0.35/page		
Letter Writing		$35/page		
Court Preparation and Court Reports	60	$125/hour		
Court Appearance: 120-minute minimum	120 (Minimum)	$500		
Telephone/Email/Text Communication***	15	$25		

*Individual sessions are based on time limits with client and/or family.

**A counselor's contracted or discounted rate varies with each insurance company. Some insurance do not allow for extended sessions without prior approval.

***Communication other than scheduling or coordinating a change in the appointment will be charged at this rate.

"Notice of Privacy Practices" are available at: www.yourkycounselor.com and you may request a copy for your files.

By signing this form, I agree to the financial responsibility of payment for the services I receive at the costs indicated above. Any exceptions will be written in by the clinician and initialed.

_____ **Date** _____

Client Name-Print Please

_____

Client Signature

Credit Card Authorization Form

Center for Child and Family Counseling, PLLC

NO SERVICES WILL BE RENDERED WITHOUT A COPY OF THIS FORM ON FILE.
Our primary goal is to take care of all expenses at the time of services. We keep a copy in your confidential record for the reasons below.

1. To bill any unpaid charges that may accrue as a result of having a deductible, co-payment, or coinsurance and or any other fees agreed upon that were not paid at the time of service delivery; fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company, EAP program or insurance company.

2. To charge any No Show Fees or Late Cancel Fees that are not paid by you through regular contact or billing.

3. Any NSF or Returned Unpaid Check amount plus returned check fees from your bank.

By providing the information below you agree to allow my office to bill the above mentioned fees and any other agreed upon fees located in the Informed Consent or Fee Schedule not paid by you in person, even if we are unable to contact you. You also agree that a $5.00 per charge fee will be added for using your card for unpaid fees that are not paid through a written or verbal request. You also agree that all NSF or unpaid checks will be charged an extra $25.00 charge plus the card fee. Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card.

Name exactly as it appears on card _____

Is this a Health Spending Account? Yes _____ No _____

Type of Card (Visa and MC ONLY) _____ Visa _____ MasterCard

Card Number _____

Expiration Date Month_____ Year_____

Security Number (3 digits back of card) _____

IS billing address for card the same as home address? Yes No (If no fill in below)

_____

_____

Phone number for card Same as Home Phone Cell Phone Other _____

By signing this I hereby understand that my card may be charged for reasons stated above.

If would you prefer to use this card as your primary billing method if so please check here Yes☐ No ☐

Client Signature _____Date _____

Center for Child and Family Counseling, PLLC

CONTACT WITH PRIMARY CARE PHYSICIAN

_____Client does not agree to contact with Primary Care Physician.

_____Client agrees to contact with Primary Care Physician:

Name:_____ Address: _____

Phone:_____

_____Client does not agree to contact with Primary Care Physician

A release of information will be completed if permission is given to contact Physician listed above.
I give consent to Center for Child & Family Counseling, PLLC and/or Janet Vessels, MS LPCC RPT-S, to provide to and/or receive information from my Physician.

Client Signature _____Date _____

Center for Child and Family Counseling, PLLC

Your Personal Concerns

Please describe the problem, in detail (who, what, when, where, how, why)

Have you seen someone else for this problem in the past? Yes ____ no _____If so, who?

If you **now** see or have been to a psychiatrist, medical doctor or therapist for this or a related mental health or medical problem please list the name, address and telephone number of the health professional on the release of information form provided to you.

Do you have any history of trauma? YES ___ No ____ Please only provide details you feel comfortable listing.

If there any family history of mental health/substance abuse? Yes ___ No ___ Please only provide details you feel appropriate.

Have you ever thought about harming yourself in anyway? YES ____NO ____ If yes please list the details as appropriate.

Do you feel like harming yourself now or in the near future? Yes ____No _____If yes please list any details as appropriate.

Do you feel like harming someone else right now? Yes ___ No ___ If yes please list the details as appropriate.

Please list all medical conditions and/or drugs you take, including caffeine, alcohol and nicotine, any illegal drugs, prescription medication, the amounts, frequency and when you/they first began to use them:

Are there any medical issues that affect you?

Who lives in your home now?

Are you close to your immediate/extended family? Yes ____ No _____

Do you work or go to school? Yes ____ No _____ Where do you work or go to school?

What is your level of education? (Check all that apply)

Dropped Out of High School _____

Currently Enrolled (High School or College) _____

High School Graduate _____

Some College _____ Graduated from College ____ Associates ____ Bachelor ____ Masters or higher _____

What do you enjoy doing when you are not working/going to school?

Are you involved in any legal problems (arrested history, DUI occurrences, incarceration, litigation)? Yes ____ No ____