kp counseling

**Client Registration Form**

Client Name: Client#:

**1, CLIENT INFORMATION**

Date of Registration Referred By

Client Name Gender Date of Birth Age

Address City State Zip

Phone Number Cell Number

Social Security # Email address

**Appointment Reminder Preference** (select one): ☐ **Text** ☐ **Phone Call** ☐ **Email**

Marital Status: ☐ Annulled ☐ Divorced ☐ Domestic Partners ☐ Married ☐ Minor ☐ Never Married ☐ Separated ☐ Widowed

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Part Time ☐ Student ☐ Minor

Employer Work Phone

Employer Address City/State/Zip

**Emergency contact** Relationship Phone

In case of an emergency, I give permission for the staff at kp counseling to call the person listed above and/or call (911) for medical assistance and to release any information that will allow for proper medical care.

**2, RESPONSIBLE PARTY INFORMATION *(for financial purposes if different than client)***

Responsible Party's Name Relationship to Client

Address Social Security # Date of Birth

City/State/Zip Phone Number ( ) Cell Number ( )

Employer Employer Address

Work Phone ( ) City/State/Zip

☐ ***Please check if you DO NOT have Medical/Health insurance coverage.***

**3. PRIMARY INSURANCE AND INSURED INFORMATION**

Name of Insured

Insureds Address

City/State/Zip

Phone ( )

Client Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer

Insured's Date of Birth

Insured's SS#

Insurance Company

Insurance ID#

Group Number

Effective Date of Coverage

**4. SECONDARY INSURANCE AND INSURED INFORMATION**

Name of Insured

Insureds Address

City/State/Zip

Phone ( )

Client Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer

Insured's Date of Birth

Insured's SS#

Secondary Insurance Company

Insurance ID#

Group Number

Effective Date of Coverage

**4. EAP INFORMATION**

Name of EAP Company Phone ( )

Authorization Number Auth Date Range

**Print Client Name** DOB

**Client Signature** Date

**Print Parent/Guardian Name** (if applicable) Date

**Parent/Guardian Signature** (if applicable) Date

**kp** counseling

**Client Consent for Treatment**

**kp** counseling is committed to helping individuals and organizations find their gifts and maximize their potential. We believe that all individuals have a light which represents their gifts and talents. We believe their light was designed by God (to their own understanding) to be used to fulfill their lives and serve others. Our mission is to help others improve the quality of their lives by focusing on building relationships with us, themselves, their families, and their community. We believe the key to a quality of life is awareness, education, and action. The human body is amazing in its ability to heal itself. Our focus is first on the health of the individual. The individual's physical and spiritual health is key to being healthy mentally and emotionally. Many times, trauma or deep-rooted wounds may interfere with the health of the individual and the focus is on the healing of those wounds for optimal living to occur. The goal is for individuals to develop skills of self-mastery, to not only have a fulfilled, quality life, but to also be a light and inspiration to others.

For the best results and for our own welfare, it is very important that you take the time to read and understand what it means to be receiving psychotherapeutic services from kp counseling. Please read the brief description below. If you understand it and choose to receive therapeutic services from kp counseling as described here, sign and date this form. If you have any questions or concerns, please speak to your therapist or one of our office staff.

1. Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you solve problems that may be limiting your satisfaction in life, and help you cope better with the feelings and challenges that you encounter in daily life.
2. The most common method of psychotherapy involves talking about your feelings, your problems or concerns, and your experiences and your situation. Other common methods involved using your imagination, keeping personal records of your experiences, and trying new and/or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions, or you may be asked to do them at home.
3. The length of psychotherapy often depends on your individual needs and the rate of your progress toward the agreed upon goals in your treatment plan. Many therapists use periodic reviews as a means of evaluating your needs, progress and satisfaction, and treatment plans are reviewed every three months at kp counseling.
4. Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by psychotherapy is rare, but you should be aware that it could happen. If you feel that you are making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your psychotherapist. If you feel that your therapist has attempted to violate you in any way – financially, physically, sexually, or otherwise – you should inform the state agency responsible for professional licensing. You are also encouraged to contact the clinical director at the agency at any time with any concerns or feedback you may have about your therapist.
5. You always have the right to choose whether to continue in psychotherapy. If you feel that you might work better with a different therapist, your present therapist or the Clinical Director at the agency should be able to offer information on possible referrals. Local mental health agencies can be found using your search engine of choice on the internet. Sometimes it is helpful to participate in different kinds of counseling in addition to or instead of psychotherapy. Some different kinds of counseling are self-help or support groups, therapeutic reading, and different forms of religious or pastoral counseling. The agency strongly supports you making the decision to participate in therapy that feels right for you. We will help you to the best of our ability to acquire appropriate care.

6. Communication is essential to successful psychotherapy. You are urged to ask questions, express concerns, and share information about your personal life with your therapist. This information must be kept private (confidential) by your therapist unless you grant permission to release it. The only exceptions to this protection of your privacy are dictated by laws and are explained in the Limits of Confidentiality form that will be reviewed with you. If you do not understand the limits of confidentiality you are urged to discuss them with the intake counselor or your therapist.
7. kp counseling's mental health providers are diverse group from various disciplines. They include licensed professional counselors (LPC), licensed clinical professional counselors (LCPC), licensed social workers (LSW), licensed clinical social workers (LCSW), licensed marriage and family therapists (LMFT), Certified Alcohol Drug Counselor (CADC), as well as graduate school interns from several graduate programs in the state who may be observing as part of their training. All other providers are licensed (fully licensed and/or in-training licensed) professionals or are actively working towards their licensure through continuing education and supervision. All providers receive supervision, meaning they consult and collaborate with other mental health professionals within our agency about their clients without divulging the client's names or identifying information. If you have any questions about your therapist or about consultation/collaboration between providers, please do not hesitate to ask him or her, or the Clinical Director.

**Audio or Video Recording of Any Session is Forbidden**

I agree that neither I nor any other participant in my session(s) will record any audio or video portion of my session without written mutual consent from myself and my provider (and any other participant as applicable). If I or any participant in my session do record any audio or video information during my treatment session(s) without written mutual consent, the session will immediately be terminated (with my obligation to pay the full fee for the session), all future treatment sessions of any kind will be canceled/terminated, and I may be permanently discharged from my provider and all providers in the kp counseling company.

**Client Information and Informed Consent for Telehealth Treatment**

Telehealth services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable counselors to provide services to individuals who may otherwise not have adequate access to care. Telehealth may be used for services such as individual, couples, or family therapy. Telehealth is a relatively recent approach to delivering care and there are some limitations compared with seeing a counselor in person. These limitations can be addressed and may be minor depending on the needs of the client and the care with the technology (cell phone, computer, etc.) which is being utilized. It is important that both the client and the counselor be in a place where there is the most privacy, as possible, during their sessions, and that the security of their technology be as up to date as possible with appropriate security protection.

**Additional Points for Client Understanding:**

- I understand that telehealth services are completely voluntary, and I can choose not to do it or not to answer questions at any time.
- I understand that none of the telehealth sessions will be recorded or photographed without my written permission.
- I understand that telehealth will be performed with encrypted platforms only. My therapist and I will work together to choose the telehealth communication system/program that will work best for my needs.

kp counseling has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telehealth session will not be the same as an in-person session since I will not be in the same room as my therapist.

- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the videoconferencing, text, or telephone connections are not adequate for the situation.
- I understand that I may experience benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

- I understand if there is an emergency during a telehealth session, as with an in-person session, my therapist will call emergency services and my emergency contact if needed clinically necessary.
- I understand that in advance of the telehealth session, a plan will be in place about how to re-connect if the connection drops while I am in a session.
- I understand that my therapist and I will create and have in place a safety plan in case of an emergency (see below).
- I understand I have the right to withhold or withdraw this consent at any time.
- I understand the laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the information, authorization, and consent to Treatment document.

**Consent:**
I consent to engaging in telehealth as part of my treatment at kp counseling. I understand telehealth includes the practice of health care delivery, diagnosis, transfer of personal health information via conversation, and psychoeducation using interactive audio, video, or date communications.

I understand the information provided above regarding telehealth. I have discussed the consent with my therapist and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth I my care.

**A Mental Health and AODA Clinic**
**Confidentiality of Alcohol and Drug Abuse Client Records**

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by the clinic, Generally, the clinic may not say to a person outside of the clinic that a client attends the clinic, or disclose any information identifying a client as an alcohol or drug abuse client unless:

1. The client consents in writing.
2. The disclosure is allowed by court order.
3. The disclosure is made to medical personnel in a medical emergency.

Violation of the Federal law and regulations by the clinic is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations.

Federal Law and regulations do not protect any information about a crime committed by a client either at the clinic or against any person who works for the clinic or about any threat to commit such crime.

Federal Law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for federal regulations.

**Confidentiality of Medical Health Client Records**

All information concerning your identity and all treatment information in your files at kp counseling shall remain confidential. Your records will not be released without your written informed consent unless as provided under sections 740 ILCS 110/ of Illinois State Statutes, 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 of the federal state statutes, 42 C.F.R. Part 2 of the federal regulations, or as otherwise allowed or required by state or federal law They may also be released to other persons with your written informed consent, or the written informed consent of a person authorized by you. Feel free to request additional information or have your Therapist/Counselor explain the circumstances under which your records may be released if you wish further clarification.

You are not required to give kp counseling any specific information. However, all information that you give will help us gain funds for the services you may receive.

All information that you give will also help your Therapist/Counselor provide you (and your family) with the best care possible. Feel free to have your Therapist/Counselor explain further if you wish clarification.

You have the right to review your file with staff present and to contest the accuracy of any statement in your file with which you disagree.

## Grievance Procedures Outline

kp counseling is devoted to providing competent mental health and AODA Treatment to our clientele. The agency would also like every client to know that he/she does have a voice in the kind of care received. Grievances involve complaints about services, breach of confidentiality or abuse. The following instructions are steps to be taken should a client feel the need for resolution of a situation. If level one does not provide satisfactory results, the client should proceed to the next level, and so on.

**Level One**
One of the most important tools in psychotherapy is the relationship between the therapist and the client. If a client has a discrepancy with the therapist, those issues should be discussed directly with the therapist. The two parties will discuss the matter and come to an agreeable resolution.

**Level Two**
Clients of kp counseling have the right to speak directly to the Clinical Director if speaking with the therapist has not helped the situation. The Clinical Director will attempt to mediate the difficulties between therapist and client.

**Level Three**
At this level, clients should place all grievances and steps that have been taken to remedy the situation in writing using the "Grievance and Complaint Summary Form" within one month of the meeting with the Clinical Director. This form may be obtained from the Client Rights Specialist/Director. The Director will review the situation and meet with the parties involved to discuss resolutions. A letter outlining the agency's position will be mailed to the parties involved within two weeks of the meeting.

## Coordination of Care Between Health Care Providers

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. If you complete a Release of Information (ROI) this form will allow your behavioral health provider to share protected health information (PHI) with your other provider. The information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, Diagnostic Assessment, and case notes, if necessary.

**Client Rights**

- You may end this authorization (permission to disclose information) at any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see applicable Notice of Privacy Practices.
- You will be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

# Medical Information Notice of Privacy Practices

Effective March 1, 2023

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice applies to the behavioral health care providers and entities that are owned or controlled by OptumHealth Holdings, LLC and which are part of an affiliated covered entity (collectively referred to herein as the "Optum Behavioral Care ACE" or "OBC ACE," which includes Refresh Mental Health) for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). References in this notice to "we," "us," and "our" mean the OBC ACE. For a list of the entities participating in the OBC ACE, please contact the Refresh Mental Health Privacy Administrator at the address listed below.

We are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you, and when we can give out or "disclose" that information to others. You have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, and if we maintain a website, we will post a copy of the revised notice on our website www.refreshmentalhealth.com. If we maintain a physical delivery site, we will also post a copy in our office. The notice will also be available upon request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

**How We Collect, Use, and Disclose Information**

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

**We have the right to** collect, use, and disclose health information for your treatment, to bill for your health care and to operate our business. For example, we may collect, use and disclose your health information:

- **For Payment.** We may collect, use, and disclose health information to obtain payment for health care services. For example, we may collect information from, or disclose information to, your health plan in order to obtain payment for the medical services we provide to you. We may ask you for advance payment.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect, information from, or disclose information to, your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information as necessary to operate and manage our business activities related to providing and managing your health care. For example, we might analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, it is no longer subject to this notice, and we may use it for any lawful purpose.

- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Reminders.** We may collect, use, and disclose health information to send you reminders about your care, such as appointment reminders with providers who provide medical care to you, or reminders related to medicines prescribed for you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment, or health care operation messages using telephone numbers or email addresses you provide to us.

**We may** collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the

institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as specified in our contract and permitted by law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out how to revoke an authorization, use the contact information below under the section titled “Exercising Your Rights.”

**What Are Your Rights**

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction other than with respect to certain disclosures to health plans as further described in this notice.**
- **You have the right to request that we not send health information** to health plans in certain circumstances if the health information concerns a health care item or service for which you or a person on your behalf has paid us in full. We will agree to all requests meeting the above criteria and that are submitted in a timely manner.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any request to modify or cancel a previous

confidential communication request must be made in writing. Mail your request to the address listed below.

- **You have the right to see and obtain a copy** of certain health information we maintain about you such as medical records and billing records. If we maintain a copy of your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect or obtain a copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as medical records and billing records if you believe the information is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on our website, www.refreshmentalhealth.com or by calling 1-855-205-0990.

**Exercising Your Rights**

- **Contacting your Provider.** If you have any questions about this notice or want information about exercising any of your rights, please call 1-855-205-0990.

- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  **Refresh Mental Health Privacy Administrator**
  **MN101-E013**
  **11000 Optum Circle**
  **Eden Prairie, MN 55344**

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

**You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not retaliate against you for filing a complaint.

kp counseling

**Client Consent for Treatment**

Client Name: Client#:

**Authorization to Release Information for Assignment of Insurance/EAP Benefits**

**Please Indicate your preference by checking either A or B below:**

☐ **A.** I hereby authorize kp counseling to release to my insurance company, EAP, and/or associate professionals any information from my medical records which may be necessary to determine benefits payable under my policy and/or expedite treatment. This information may be transmitted electronically with appropriate assurances for confidentiality. I further authorize payment directly to kp counseling for the benefits of otherwise payable to me for the amount which covers but does not exceed charges for services delivered. I hereby guarantee payment of all charges incurred for services rendered which are not covered by this assignment or by insurance benefits. I am also aware that any co-pays, coinsurance, deductible amounts are expected at the time of service.
I understand if a Release of Information is completed for person(s) and/or organizations that are not health care providers, health plans or a health care clearing house, who must follow the federal privacy standards, the health information disclosed because of this authorization may no longer be protected by the federal privacy standard and my health information may be re-disclosed with my authorization.
Please Note: If consent has been given to release information to my insurance company, I understand that some communications may be transmitted by facsimile ("fax") or electronically. Although every attempt is made to ensure confidentiality of these transmissions, the nature of this method cannot absolutely guarantee confidentiality.

**OR**

☐ **B.** I DO NOT authorize my insurance/EAP company to be billed and I DO NOT authorize any information from my medical records to be released to my insurance company. I understand that I am solely responsible for private/self-payment of all charges incurred with kp counseling. I am aware that payment for services is expected at the time of service.

**Acknowledgement**

I acknowledge that I have received the written "Grievance Procedure for Community Services" and "Notice of Privacy Practices". I understand the "Clients Rights and the Grievance Procedure for Community Services" and acknowledge the understanding of this process by signing this acknowledgement.

I have read and understand the above confidentiality policy of client records. I understand that my records may be released to other people without my informed consent only as provided by State and Federal law, or to persons with my informed consent or the informed consent of a person authorized by me.

I have read the policy regarding the prohibition of audio and video recording. I agree to abide by this policy.

I have read the authorization to release information for assignment of Insurance/EAP benefits, have indicated my preference, and am acknowledging my understanding of the information hereinabove.

Your signature indicates that you have understood the above description of psychotherapy and are consenting to psychotherapy & telehealth if applicable with the understanding that you retain the right to review and revise the decision at later points in time.

Print Client Name_____ DOB_____

Signature of Client_____ Date_____

Print Parent/Guardian Name*(if applicable)*_____

Signature of Parent/Guardian*(if applicable)*_____ Date_____

kp counseling

**Client Intake Assessment**

Client Name: Client#:

**Instructions:** Please answer the following questions to the best of your ability as this will be helpful for your therapist in better understanding your situation. For children or minors please complete all sections that apply.

Client Name:_____Age:_____DOB:_____

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Black or African American/ American Indian or Alaska Native
- ☐ Declined to specify
- ☐ Hispanic
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Pacific islander
- ☐ Other
- ☐ White
- ☐ White/Asian
- ☐ White/Black or African American
- ☐ White/American Indian or Alaska Native

**PRESENTING PROBLEM**

Check if you are experiencing any of the following problems:

- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Anxiety
- ☐ Depression
- ☐ Family / Friends
- ☐ Marital / Relationships
- ☐ Sexual issues / Orientation
- ☐ Eating habits
- ☐ Stress Management
- ☐ Physical health
- ☐ Financial
- ☐ Gambling issues
- ☐ other_____

**Please describe why you checked the above items / what brings you to counseling today:**

_____

_____

_____

_____

_____

**What goals would you like to accomplish in treatment:**

1. _____

_____

2. _____

_____

**3.** _____

_____

**What would you consider your greatest strengths:**

_____

_____

kp counseling

**Client Intake Assessment**

Client Name: Client#:

## SYMPTOM CHECKLIST

The following is a list of symptoms that have to do with various psychological problems. Please circle the number from zero (0) to four (4) that best describes how much this symptom or problem bothers you. Use the following scale:

**0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely**

| **In the past week, how much were you bothered by:** | **Not at all** | **little bit** | **Mod** | **Quite bit** | **Extremely** |
|---|---|---|---|---|---|
| 1. Feeling depresses, sad, blue, down, unhappy most of the time | 0 | 1 | 2 | 3 | 4 |
| 2. Feeling easily annoyed or irritated | 0 | 1 | 2 | 3 | 4 |
| 3. Feeling no interest in things or avoiding enjoyable activities, family, or friends | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling tired all the time even with adequate sleep | 0 | 1 | 2 | 3 | 4 |
| 5. Trouble concentrating; can't stay focused on activities | 0 | 1 | 2 | 3 | 4 |
| 6. Feeling lonely even when you are with people | 0 | 1 | 2 | 3 | 4 |
| 7. Feeling hopeless about the future | 0 | 1 | 2 | 3 | 4 |
| 8. Significant increase or decrease in appetite or weight | 0 | 1 | 2 | 3 | 4 |
| 9. Sleeping problems; can't fall asleep, restless sleep, sleeping too much | 0 | 1 | 2 | 3 | 4 |
| 10. Thought of suicide: thinking "I wish I were dead", "life isn't worth living anymore" | 0 | 1 | 2 | 3 | 4 |
| 11. Suicide attempt: Intent or action to hurt or kill self with pills, weapons, cuts etc. | 0 | 1 | 2 | 3 | 4 |
| 12. Racing thoughts, rapid speech, little or no need for sleep, impulsive traveling and/or spending money | 0 | 1 | 2 | 3 | 4 |
| 13. Doing things without thinking and often getting yourself into a jam | 0 | 1 | 2 | 3 | 4 |
| 14. Feeling so restless you could not sit still | 0 | 1 | 2 | 3 | 4 |
| 15. Feeling anxious: worrying excessively or worry about many things | 0 | 1 | 2 | 3 | 4 |
| 16. Feeling tense or keyed up | 0 | 1 | 2 | 3 | 4 |
| 17. Spells of terror or panic | 0 | 1 | 2 | 3 | 4 |
| 18. Fearful feelings of being humiliated in social situations | 0 | 1 | 2 | 3 | 4 |
| 19. Feeling uneasy in crowds or in open spaces | 0 | 1 | 2 | 3 | 4 |
| 20. Feeling afraid to travel on buses, subways, trains, or planes | 0 | 1 | 2 | 3 | 4 |
| 21. Feeling inferior to others | 0 | 1 | 2 | 3 | 4 |
| 22. Having to avoid certain things, places, or activities because they frighten you | 0 | 1 | 2 | 3 | 4 |
| 23. Sudden re-experiencing of feelings, thoughts images of traumatic event | 0 | 1 | 2 | 3 | 4 |
| 24. Temper outbursts that you could not control | 0 | 1 | 2 | 3 | 4 |
| 25. Feeling "nothing" or numb, as if blocked as in taking a pain killer | 0 | 1 | 2 | 3 | 4 |
| 26. Recurrent thoughts, impulses, or images that are intrusive and troubling | 0 | 1 | 2 | 3 | 4 |
| 27. Excessive repeating of an activity that you couldn't resist even though it sometimes seems foolish (e.g., cleaning, washing hands, counting, etc.) | 0 | 1 | 2 | 3 | 4 |
| 28. Feeling that you are watched or talked about by others | 0 | 1 | 2 | 3 | 4 |
| 29. Seeing or hearing things outside yourself that others tell you are not really there | 0 | 1 | 2 | 3 | 4 |
| 30. The idea that someone else can control your thoughts | 0 | 1 | 2 | 3 | 4 |
| 31. Feeling that most people cannot be trusted | 0 | 1 | 2 | 3 | 4 |
| 32. Persistent fears about health problems despite doctors finding nothing wrong | 0 | 1 | 2 | 3 | 4 |
| 33. Episodes of binge eating, purging/vomiting, or periods of not eating | 0 | 1 | 2 | 3 | 4 |
| 34. Feeling others are to blame for most of your troubles | 0 | 1 | 2 | 3 | 4 |
| 35. Having urges to break or smash things or injure someone | 0 | 1 | 2 | 3 | 4 |
| 36. Getting into frequent arguments with family members, friends, or co-workers | 0 | 1 | 2 | 3 | 4 |
| 37. Difficulty managing children, feel parenting skills are deficient | 0 | 1 | 2 | 3 | 4 |
| 38. Occupational concerns: job dissatisfaction, problems with employer/co-workers | 0 | 1 | 2 | 3 | 4 |
| 39. Other | 0 | 1 | 2 | 3 | 4 |

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**Client Intake Assessment**

Client Name: Client#:

For the next several questions, please circle the number that represents how frequently you use any of the following substances. Use the following scale:

**0 = Never 1 = In past, not currently 2 = Monthly 3 = Weekly 4 = Almost Daily**

| | Never | In Past | Monthly | Weekly | Daily |
|---|---|---|---|---|---|
| a. Caffeine: coffee, caffeinated beverages | 0 | 1 | 2 | 3 | 4 |
| b. Nicotine: cigarettes, cigars, vape | 0 | 1 | 2 | 3 | 4 |
| c. Beer / Liquor | 0 | 1 | 2 | 3 | 4 |
| d. Marijuana, hash | 0 | 1 | 2 | 3 | 4 |
| e. Sedatives: tranquilizers, sleeping pills, barbiturates, valium, Xanax, Quaaludes | 0 | 1 | 2 | 3 | 4 |
| f. Inhalants/Solvents: glue, toluene, gasoline | 0 | 1 | 2 | 3 | 4 |
| g. Stimulants: amphetamines, "speed", Ritalin | 0 | 1 | 2 | 3 | 4 |
| h. LSD, psychedelics, mescaline, peyote, DMT, ecstasy | 0 | 1 | 2 | 3 | 4 |
| i. Cocaine / Crack / Crank, coca leaves | 0 | 1 | 2 | 3 | 4 |
| j. Opioids: heroin, codeine, Demerol, morphine, Percodan, methadone, Darvon | 0 | 1 | 2 | 3 | 4 |
| k. PCP, "angel dust" | 0 | 1 | 2 | 3 | 4 |
| l. Other: | 0 | 1 | 2 | 3 | 4 |

## PSYCHOLOGICAL HISTORY

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions? Yes No

If yes, what and when:

Have you ever been in counseling or psychotherapy before? Yes No

If yes, where and when:

Have you had any past hospitalizations for emotional problems? Yes No

If yes, when and where:

Have you ever intentionally hurt yourself or made a suicide attempt? Yes No

If yes, explain how and when:

Client Name: Client#:

## MEDICAL HISTORY

Check if you are currently experiencing or have ever experienced:

| | | |
|---|---|---|
| ☐ Head Injury | ☐ Anemia | ☐ Asthma or Hay Fever |
| ☐ Heart (trouble, disease, surgery) | ☐ Thyroid problem | ☐ Sinus problems |
| ☐ Heart murmur | ☐ Kidney or bladder problems | ☐ Weight change/change in appetite |
| ☐ Heart pacemaker | ☐ Liver disease | ☐ Glaucoma/Cataracts |
| ☐ Rheumatic fever or heart disease | ☐ Jaundice/rashes/sores | ☐ Neurological disorders |
| ☐ Abnormal blood pressure | ☐ Hepatitis – type A B C | ☐ Memory Loss |
| ☐ Ulcers/Abdominal Pain | ☐ Arthritis / Rheumatism | ☐ Venereal disease |
| ☐ Diabetes | ☐ Headaches | ☐ HIV positive/AIDS/ARC |
| ☐ Epilepsy (Seizure Disorder) | ☐ Hemophilia/blood disease | ☐ Hearing Impaired |
| ☐ Tuberculosis or Lung disease | ☐ Sickle Cell disease | ☐ Visual Problems |
| ☐ Emphysema | ☐ Stroke | ☐ Broken Bones |
| ☐ Cancer / Tumors | ☐ Fainting Spells | ☐ Other |

If you checked any of the above medical items, please explain:_____

Are you currently experiencing any physical pain? Yes No

If yes, where is the pain_____

Are you currently receiving care for your pain? Yes No

By whom?_____

Do you have any allergies or reactions to medications? Yes No

If yes, what medications:_____

Who is your primary care physician (PCP):_____When was your last physical?_____

Are you taking any prescribed medications?

| Name of Medication | Dosage and Frequency | Reason | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please indicate any herbal or homeopathic substances that you are currently taking:_____

kp counseling
**Client Intake Assessment**

Client Name: Client#:

## FAMILY HISTORY

Please list Parents, Siblings, Spouse, Children, and Significant Relatives/Others:

| Name (First & Last) | Relationship | Age | School/Occupation | City of Residence |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

How many pregnancies have you experienced?

Marital Status: ☐ Annulled ☐ Divorced ☐ Domestic Partners ☐ Married ☐ Minor ☐ Never Married ☐ Separated ☐ Widowed

# of Marriages: If married, how long?

If past divorce: when and why?

Who currently lives in your household?

Is there a history of depression, anxiety, alcoholism, or other mental health conditions in your family? Yes No

If yes, who? What was the problem? Did they receive treatment or medication?

## TRAUMA HISTORY

Have you ever experienced any emotional/mental, physical, or sexual abuse? Yes No

If yes, please explain:

Have you ever been accused of assaulting or inappropriately touching someone? Yes No

If yes, please explain who/when?

Does the use of alcohol or drugs by someone close to you contribute to your problems? Yes No

If yes, please explain:

Did you grow up in a home in which a parent abused alcohol or drugs? Yes No

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**Client Intake Assessment**

Client Name: Client#:

## EDUCATIONAL & VOCATIONAL HISTORY

What is your highest grade level completed?_____ Do you have a GED in lieu of diploma? Yes No

What High School did you attend?_____

How did you do academically in school?_____

How was your conduct throughout school?_____

If attended college, at what college, and what is your degree?_____

What is your occupation / job / employer?_____ For how long?_____

Have you ever been fired? Yes No If yes, explain:_____

## MILITARY HISTORY

Did you ever serve in the military? Yes No Branch of Military?_____

Date / Type of Discharge:_____ Do you have any combat history? Yes No

## LEGAL HISTORY

Do you have a legal history consisting of past or current:

| | | | |
|---|---|---|---|
| Arrests | Yes | No | Explain:_____ |
| Restraining Order | Yes | No | Explain:_____ |
| Divorce/Custody | Yes | No | Explain:_____ |
| Incarceration | Yes | No | Explain:_____ |
| Probation | Yes | No | Explain:_____ |
| Other | Yes | No | Explain:_____ |

## CULTURAL/RELIGIOUS/SPIRITUAL HISTORY

What is your ethnic or cultural heritage?_____

In what religion did you grow up?_____ Your current religion?_____

How do your ethnicity or religious beliefs influence your life?_____

Print Client Name_____ DOB_____

Client Signature_____ Date_____

Print Parent/Guardian Name (if applicable)_____

Parent/Guardian Signature (if applicable)_____ Date_____

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**GAD-7 and PHQ-9**

Date:_____ Client#:_____

Client Name:

## Anxiety Questionnaire (GAD-7)

| **Over the last 2 weeks, how often have you been bothered by the following problems?** (Circle your answer) | Not at all | Several Day | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

Total Score_____

**If you checked off any problems, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people?**

Not difficult at all:_____ Somewhat difficult:_____ Very difficult:_____ Extremely Difficult:_____

## Depression Questionnaire (PHQ-9)

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** (Circle your answer) | Not at all | Several Day | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself -- or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

Total Score_____

**If you checked off any problems, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people?**

Not difficult at all:_____ Somewhat difficult:_____ Very difficult:_____ Extremely Difficult:_____

**kp** counseling

**Client Financial Agreement**

The following agreement states your financial obligation for psychotherapy counseling provided by kp counseling.

1. I am responsible for all fees incurred. Individual sessions are based on a 53+ minute session but may vary depending on the treatment needed at each session.

2. All fees are due at the time of service. You can choose to pay at the time of service yourself or have a credit card on file that will be charged on the day of service for any co-pays, deductibles, coinsurance, or self-pay rates due. If you choose to pay at the time of service and more than 3 payments are missed all future appointments may be cancelled until the account is made current or an auto payment plan is set up. kp counseling reserves the right to attempt to collect any unpaid bills by reasonable means. Non-payment of fees can be cause for termination from treatment.

3. We offer complimentary benefit checks for both in and out of network levels of care. When you make your initial appointment our intake team will ask for your insurance information so we can verify your benefits prior to your appointment. Our Insurance Verification Team will contact you to go over your insurance plan benefits and our contracted rates with your insurance company to explain what you will be responsible for paying. The benefits given to you are what we were quoted by your insurance company, and we cannot guarantee the accuracy of the information until we begin receiving the explanation of benefits. All quotes are not a guarantee of payment, and are subject to the terms, conditions, and exclusions of your health plan at the time of service.

4. Our contracted rates with your insurance company are subject to change at any time and may result in an increase in your out-of-pocket responsibility. We may not be aware of this change until the explanation of benefits (EOB), or explanation of payment (EOP) is received.

5. I understand if I opt out of using my insurance on the Consent for Treatment, I will be given a good faith estimate as required by the No Surprises ACT.

6. I understand if I agree to using my insurance on the Consent for Treatment and decide later to opt out of using my insurance, I will need to complete a new Consent for Treatment or the Elect to self-pay for services form and will also be given a good faith estimate as required by the No Surprises ACT.

7. I understand it is my responsibility to obtain a PCP referral or insurance/EAP authorization if required by my plan.

8. I understand if there are any changes to my insurance, it is my responsibility to inform kp counseling. If I fail to report changes and update paperwork, I understand I will be responsible for all charges.

9. **No show appointments or appointments cancelled without 24-hour notice will result in a $60.00 fee for psychotherapy services.** Your insurance company will not reimburse you for late cancellations or for not showing up for services. It will be your responsibility for payment at or before your next appointment. All cancellations must be made by phone. Emails and text messages are not acceptable for cancellations.

10. Clients who elect to only do telehealth sessions via video or phone must have a credit card on file. If you do not want to put a credit card on file, then only in person sessions are allowed.

11. If you wish to have any information provided to another doctor, family member for financial, scheduling, records, etc. you must fill out a Release of Information (ROI) form. This Release is good for one year unless you request it be removed.

12. Clients who file bankruptcy: If we receive a letter from the Court discharging a client in a Chapter 7 Bankruptcy the account balance is written off to bad debt. If you want to continue or come back for therapy, we will verify your insurance benefits and payment must be made at the time of service for any amount responsible by the client. You will not be allowed the visit if payment is not made.

13. Return Checks: An NSF charge of $25.00 for any returned checks.

14. I understand kp counseling accepts payment by check or debit/credit card only.

15. kp counseling, ltd. Fee Schedule is available upon request.

**kp** counseling

**Client Financial Agreement**

Client Name: Client#:

Client Name **DOB**

Responsible Party (if different than the client)

Responsible Party's Relationship to Client

**Please Indicate your payment preference by checking either A or B below:**

☐ A. I will pay myself at the time of service.

**OR**

☐ B. I authorize kp counseling to put my credit card on file to be charged for all services. **(List credit card detail below)**

I understand by putting my card on file it will be charged for all services due (deductible/coinsurance, co-pay, or self-pay amounts due as well as any missed appointment fees). I understand that if my insurance carrier also reimburses kp counseling I will be reimbursed for any over payment.

Name on card

Address City/State/Zip

Credit card number Phone#

Expiration date / 3-digit security code Zip Code

Signature of cardholder: Date:

**I have carefully reviewed all the above statements regarding the Client Financial Agreement and accept all the above conditions as indicated.**

Print Client Name DOB

Client Signature Date

Print Parent/Guardian Name (if applicable)

Parent/Guardian Signature (if applicable) Date

**You may change your payment preference at any time by completing a new Financial Agreement. If you have any questions, please contact our Billing Department 779-368-0060 x 996.**

**kp** counseling

**CLIENT CONSENT TO BE CONTACTED FOR POST-VISIT SATISFACTION SURVEY FORM**

Client Name: Client#:

**Client Name**_____ **DOB**_____

**kp** counseling, Ltd. ("Center") is committed to ensuring patients' satisfaction of services received. Center has contracted with a third party – Burke, Inc. – to conduct satisfaction surveys on our behalf. The survey will be provided online and will take no more than 10 minutes to complete. If you agree to be contacted to participate in a survey about our services, please indicate your consent by checking one of the boxes below:

☐ I agree to be contacted by Burke, Inc. via email (at the email listed below) for purpose of the survey and understand that the invitation will mention Center. I acknowledge and agree that these messages, which may contain Protected Health Information, will be sent via unencrypted means and there is some risk of disclosure or interception of the messages.

Email Address: _____

I understand that this consent may be withdrawn by me at any time via the email I receive from Burke, Inc., via telephone by calling **779.368.0060 or** via email message at **mail@kpcounseling.com**. I understand that my withdrawal of consent to be contacted for a post-visit satisfaction survey shall not withdraw my consent to otherwise be contacted by Center.

☐ I do not wish to be contacted for the purposes of this survey.

**Signature**

I confirm that I have read and fully understand the above information prior to my signing and all of my questions regarding this form have been answered to my satisfaction. I agree that I am signing this Consent to be Contacted for Post-Visit Satisfaction Survey Form freely and voluntarily. I understand that my consent given with my signature below will remain in effect unless and until I cancel such consent in writing pursuant to the terms set forth above.

Print Client Name_____ DOB_____

Client Signature_____ Date_____

Print Parent/Guardian Name (if applicable)_____ Date_____

Parent/Guardian Signature (if applicable)_____ Date_____