Center for Child and Family Counseling, PLLC
1315 West Main, Suite A, Lexington, KY 40508 Telephone: 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 for you and/or your family, please read and complete the information in this packet.

1. Client and Intake information.
2. Notice of Privacy Practices Handout is available online and in the office.
3. Please note that if more space is needed turn page over and continue there.
4. Please check out and review the Parent Handbook on our website.

Center for Child and Family Counseling, PLLC

<u>This Information is required before services are provided.</u>

Client and Intake Information

Full Name: _____ SS# _____DOB _____

Address: _____City_____ Zip_____

Home Phone Number _____ Cell _____Work _____

Emergency Contact _____Emergency number _____

Parents Name, if a Child/ Adolescent _____

Insurance Subscriber (individual whose insurance is providing the coverage) _____
(please include all alpha characters)

Subscriber's DOB _____ Subscriber's ID# _____

Effective Date _____ Subscribers Group Number _____

Subscribers Employer _____

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

Insurance Claims address:
_____
City State Zip

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. *****

Is Preauthorization required? YES ☐ NO ☐ If yes, please continue below.

Have you been preauthorized for this visit? YES ☐ NO ☐

Do you have the authorization number? YES ☐ NO ☐ Authorization # _____

Please list number of session authorized _____

(Note: medical and mental health deductibles may differ and be calculated separate)

Do deductibles apply for your visits? YES ☐ NO ☐ Amount _____

Has the deductible been met? YES☐ NO ☐ If not, the deductible amount will be charged until met.

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

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

Is this an Employee Assistance Program (EAP) referral/Visit? YES ☐ NO ☐ How many visits on your EAP _____

A copy of the "Notice of Privacy Practices" is available on our website at http/:www.yourkycounselor.com and in the office at your request.

Informed Consent Information & 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.

WELCOME

Thank you for seeking services at the Center for Child and Family Counseling, PLLC. We look forward to serving your mental health care needs through an array of services available to you, your child and/or your family. "Informed Consent" is a legal document that outlines our general services. If you would like a copy of your signed document, please ask your counselor.

Provision of Services

I understand that the Center for Child and Family Counseling, PLLC and/or its independent contracted counselors offer a variety of clinical services to children, adolescents, and family/couples including: intake assessment, individual, crisis intervention, group counseling, supervised visitation, limited evaluations and testing, court testimony in the role of the person's mental health provider, workshops and referral. During the initial assessment, my counselor and I will work together to determine how best to serve my needs. I further understand that appropriate referrals will be provided to me if it is determined that I would be best served by another community resource.

Nature of Services

I understand that there may be both risks and benefits associated with participation in counseling. Counseling may improve my ability to relate to others, provide a clearer understanding of myself, my values, and my goals, and an ability to deal with everyday stress. Although counseling can be beneficial to many people, it may not be helpful for everyone. Therefore, it is essential that you discuss any questions or discomfort you might have with your counselor.

Center for Child and Family Staff

The Center for Child and Family Counseling is staffed with Licensed Psychological Practitioners, Licensed Professional Clinical Counselors and Associates, Licensed Marriage and Family Therapists, Counseling/Psychology Interns, and Doctoral Psychology/ Counseling Interns. Interns work under the supervision of licensed professionals and will inform you of their current supervisor's name and license number at your first meeting.

Confidentiality

I understand that Center for Child and Family Counseling Staff and counselors maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Effective counseling sometimes requires that staff members share confidential information with other staff members.

I understand that no records or information about me will be released from this Center without my permission, **except under certain circumstances:**

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. If a valid subpoena is issued for my records or a signed court order by a Judge directs the release of information.
7. Any litigation initiated by the client related to treatment.
8. Any abuse of the elderly, with mental illness or who cannot care for themselves properly.

Attendance

I agree that while I am seeing a counselor or participating in a group/workshop, whenever possible, I will notify the counselor **at least 24 hours** in advance if I know I will miss a session. I understand that if I do not show for an individual session and do not call, it may count towards my allotted number of sessions for EAP services, where available. You may leave a message on our voice mail and email.

No Show/Late Cancel Policy

I agree that I understand the Center for Child and Family Counseling has a 24-hour appointment cancellation policy, which states you must change or cancel your appointment at least 24 hours ahead of the scheduled time. We have a very high demand for our services and non-cancelled **(*No Show/Late Cancel)** appointments translate into missed opportunities for others in need of timely services. Please feel free to clarify this policy with your counselor. (**No Show* *is defined as not calling to cancel your appointment or calling to cancel with less than 24 hours notice. There are a few exceptions such as a last minute illness or emergency.*) A Counselor may to waive the charge as their discretion.

Records
Your records may be stored "on paper" and/or electronically and include the information you provided and information about any interactions (individual/group counseling, phone calls, consultation, emails, etc.) with our staff. This information is only accessible within our office and computer systems. All employees sign confidentiality agreements or are required to maintain your privacy and confidentiality according to their license and ethical standards. Your financial records, billing information, is separate from your medical information. You, as the client, may receive one free copy of your records. Any records provided to attorneys, or others will be copied at a cost 0.35 cents per page.

Contact Us
Each Counselor may provide their personal cellular phone number or email to contact them. The office number is available for messages. Email may NOT be a completely confidential means to contact us. Counseling is not provided over email and is generally used for scheduling appointments or very brief questions.

Contacting You
In order to keep my relationship with my counselor confidential, the best way to contact me should the need arise is noted below. I am aware that information exchanged over a cell phone and e-mail could be intercepted by an outside party.

It is OKAY to leave a message	Please check all that apply	
Cell Phone _____	YES ☐	NO ☐
Home Phone_____	YES ☐	NO ☐
Work Phone _____	YES ☐	NO ☐
Email address _____	YES ☐	NO ☐

Financial Responsibility for Payment of Services
Fees are due at the time of service delivery. Prices may be reduced for shorter time periods. Cash, check or credit cards are accepted forms of payment. A $5 fee will be charged for using credit cards. Clients are responsible for payment of delivered services. We will make an attempt 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, and any fee not covered by your insurance provider.

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.

Service	**Time/ Minutes**	**Cost**
Initial Intake	60	$125
45 minute Individual session*	45-50	$100
45 minute session with a family	45-60	$125
Group Session per Individual	90	$40
Group Session per Couple	90	$45
Marriage / Couple Counseling	45-50	$125
Marschak Interaction Method (MIM)	Approximately 7 hours	$700
Other Assessments involving written reports	Per hour basis	
Supervised Visitation	55	$75
Therapeutic Supervised Visitation	55	$100
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
Letter Writing		$35/page
Court Preparation and Court Reports		$75/hour
Court Appearance per Counselor present	*** 120 minutes minimum	$300
Telephone Consultation	15	$25

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.

We require some form of payment at the time of service. If you do not know if you have a deductible or co-pay payment the Center for Child and Family, PLLC will accept a payment of $85.00 for each session until information is received on deductibles, co-pays and coinsurance.

As a courtesy to you, our billing department will assist you in submitting your insurance forms. 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.

In the event your account is not paid within 90 days or your balance exceeds $500, collection proceedings will be instituted. If we have to refer your account to collections, you will be responsible for all costs of collections including reasonable collection agency fees, attorney fees, and court costs.

If you have insurance, please understand that it 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 fee of each of these visits at the rate listed above.***

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.

If there are any concerns with the Center for Child and Family Counseling services that you cannot discuss with your counselor, please contact the Owner, Janet Vessels at (859) 554-6028.

Consent for Treatment and Agreement for Financial Responsibility
I understand and agree to the limits of confidentiality 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 and/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.

I certify that I have read, understand, and agree to abide by the information outlined above concerning mental health services and the financial. I hereby give my consent to authorize the Center for Child and Family Counseling, PLLC to evaluate, treat, and/or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information.

Client Signature _____ **Date** _____ **Client Printed Name** _____

Parent Signature _____ **Date** _____

Parent Signature _____ **Date** _____

Credit Card Authorization Form

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. Also to collect 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 Managed Care Company.

2. To bill any Fail to Keep Appointment/No Show Fees or late cancel (canceling with less than 24 notice) fees not paid by you through regular contact or billing. See Fail to Keep Appointment (*No Show)/ Late Cancel policy in "Informed Consent" form.

3. Any NSF fee or Returned Unpaid Check amount.

By providing the information below you agree to allow this 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 service charge fee will be added for charging your credit card. You also agree that all NSF or unpaid checks will be charged an extra $30.00 charge. 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 _____

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 your: Home Phone Cell Phone Other _____

Client or Parent Signature _____Date _____
By signing this I hereby understand that my card may be charged for reasons stated above.

Would you prefer to use this card as your primary billing method? If so please check here **Yes☐ No ☐**

For Office Use: Name: _____

Questionnaire for Primary Caregivers

Date: _____ Person Completing Form: _____ Relationship to Child: _____
Child's Name: _____Date of Birth: _____Age: ____
Mother's Name: _____Date of Birth: _____
Mother's Occupation and Work Hours: _____
Father's Name: _____ Date of Birth: _____
Father's Occupation and Work Hours: _____
Email Addresses for Parents:_____
Child's School: _____ Teacher: _____ Grade: _____Phone #_____
Who has Custody of the child? _____ (please provide copy of custody order for the file)

List all those living in the child's home:

Name	Relationship	Age/School/ Occupation

List other persons closely involved with the child but not living in the home._____
_____

What are you concerns about your child that made you bring him/her to counseling?_____
_____

DEVELOPMENTAL HISTORY
Describe any difficulties mother experienced during pregnancy: (emotional status during pregnancy, excessive nausea, serious illness, drug or alcohol use): _____
_____

Describe any major difficulties during labor or delivery: (Mother's health at time of delivery or prenatal complications type of delivery) _____
_____

Were child's developmental milestones met on time (Walking, talking, toilet training, etc.)?
_____
_____
Describe the first year of life (early feeding and attachment behavior, how easy was it to calm or soothe the baby?)
_____
_____

Any medical history: (Hospitalizations, medications, other evaluations, hearing, vision status, injuries)
_____
_____

CHILD AND FAMILY INFORMATION
Please describe and stressful or traumatic events your child has experienced: _____
_____
_____

Please describe how your child is functioning at school (academically, socially, and behaviorally):
_____
_____
Please list any on-going medications your child has or is taking and describe for what purpose:
_____
_____

For Office Use: Name: _____

Has your child been seen for assessment or counseling? (If yes, indicate name of professional, date/place of services, for what purpose and any diagnosis provided)

_____

_____

Please describe your relationship with your child:

_____

_____

Please describe how your child gets along with other family members:

_____

_____

How is your child disciplined and by whom?

_____

_____

Please describe any concerns about your family listed below:

Health concerns: _____

Mental Illness: _____

Alcoholism/drug addiction: _____

Death in family: _____

Job loss: _____

Marital Difficulties: _____

Physical/sexual/emotional abuse: _____

Other:_____

_____

Were there any major disruptions in your child's life? (deaths/ losses-people or pets, absences, etc., problems in separation with caretakers, day care, preschool, school experiences, homelessness, disasters/catastrophic events):

_____

_____

Describe your child's personality: _____

_____

Describe your child's favorite activities:_____

_____

What do you like best about your child? _____

_____

How you spend time with your child (activities or things you do together)?

_____

_____

_____

For Office Use: Name: _____

Symptom/Problem Checklist (Adapted from the Achenbach Child Behavior Checklist)

Please check if your child is experiencing any of the following:

SYMPTOM	FREQUENTLY	SOMETIMES	PLEASE DESCRIBE
Difficulty sleeping			
Nightmares			
Startles easily, very jumpy			
Shows little or no emotion			
Unusually clingy			
Afraid to be alone			
Avoids certain people, things, place			
Difficulty concentrating or focusing			
Stomachaches, headaches			
Little sense of joy or happiness			
Cries a lot			
Talks about or has attempted suicide			
Hurts self on purpose			
Change in eating habits			
Frequent tantrums or irritability			
Increased aggression			
Hurts animals on purpose			
Fascinated with fires or sets fires			
Hides food			
Wets bed or soils self			
Refuses to go to the bathroom			
Urinates in place other than bathroom			
Washes self excessively			
Masturbates excessively			
Touches other inappropriately			
Engages in risky behaviors			
Abuses alcohol/drugs			
Lies/steals			
Has unusual tics or mannerisms			
Doesn't trust others			
Poor peer relationships			
Says does not self/ body			

Are there any other symptoms or behaviors you are concerned about:

_____

_____

_____

For Office Use: Name: _____

Mother's Background:

Where were you raised and by whom? Describe past/current relationship with your parents:

_____

_____

List brothers and sisters, their ages, whereabouts, current relationship you have:

_____

_____

Describe any of the following you/your family experience during childhood and how it affected you (physical/sexual abuse, neglect abandonment, spousal abuse divorce, other trauma)

_____

_____

Who were you closest to when you were a child? Describe the relationship with that person:

_____

_____

How were you disciplined and by whom?

_____

Describe the happiest time/experience you recall from your childhood:_____

Describe the saddest time/experience you recall from your childhood:

_____

Describe if you or any relatives have ever had any of the following:

Serious illness □	Depression/ Bipolar Disorder □	Anxiety Disorder □	Obsessive – Compulsive Disorder □
Eating Disorder □	Alcoholism /Drug Abuse □	Learning Disability/ ADHD □	Criminal Conviction □

Please add any other information about your background that you feel is important:

_____

_____

_____

_____

Father's Background:

Where were you raised and by whom? Describe past/current relationship with your parents:

_____

_____

List brothers and sisters, their ages, whereabouts, current relationship you have:

_____

_____

Describe any of the following you/your family experience during childhood and how it affected you (physical/sexual abuse, neglect abandonment, spousal abuse divorce, other trauma) _____

_____

Who were you closest to when you were a child? Describe the relationship with that person: _____

_____

How were you disciplined and by whom? _____

_____

Describe the happiest time/experience you recall from your childhood:

_____

Describe the saddest time/experience you recall from your childhood:

_____

Describe if you or any relatives have ever had any of the following:

Serious illness □	Depression/ Bipolar Disorder □	Anxiety Disorder □	Obsessive – Compulsive Disorder □
Eating Disorder	Alcoholism /Drug Abuse	Learning Disability/	Criminal Conviction

For Office Use: Name: _____

□	□	ADHD □	□

Pease Check box as needed.

_____
_____
_____

Background of Other Primary Caregivers (Step-parents, foster-parent, Common-Law Partner)
Where were you raised and by whom? Describe past/current relationship with your parents:

_____
_____

List brothers and sisters, their ages, whereabouts, current relationship you have:

_____
_____

Describe any of the following you/your family experience during childhood and how it affected you (physical/sexual abuse, neglect abandonment, spousal abuse divorce, other trauma)

_____
_____

Who were you closest to when you were a child? Describe the relationship with that person:

_____

How were you disciplined and by whom?

_____

Describe the happiest time/experience you recall from your childhood:

_____

Describe the saddest time/experience you recall from your childhood:

_____

Describe if you or any relatives have ever had any of the following:

Serious illness □	Depression/ Bipolar Disorder □	Anxiety Disorder □	Obsessive – Compulsive Disorder □
Eating Disorder □	Alcoholism /Drug Abuse □	Learning Disability/ ADHD □	Criminal Conviction □

Please add any other information about your background that you feel is important:

_____
_____
_____
_____
_____

Background of Other Primary Caregivers (Step-parents, foster-parent, Common-Law Partner)

Where were you raised and by whom? Describe past/current relationship with your parents: _____

_____

List brothers and sisters, their ages, whereabouts, current relationship you have:

_____

Describe any of the following you/your family experience during childhood and how it affected you (physical/sexual abuse, neglect abandonment, spousal abuse divorce, other trauma)

_____
_____

Who were you closest to when you were a child? Describe the relationship with that person:

_____

How were you disciplined and by whom?

_____

Describe the happiest time/experience you recall from your childhood:

_____

Describe the saddest time/experience you recall from your childhood:

_____

Describe if you or any relatives have ever had any of the following:

Serious illness	Depression/ Bipolar Disorder	Anxiety Disorder	Obsessive – Compulsive Disorder □

For Office Use: Name: _____

Eating Disorder ☐	Alcoholism /Drug Abuse ☐	Learning Disability/ ADHD ☐	Criminal Conviction ☐

Please add any other information about your background that you feel is important:

_____
_____
_____
_____

_____