To Simply Live

Ryan Vogt-Foster, LLC.
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(Child/Teen) Personal Information Sheet

Date: ___/___/____

Name: ____ DOB: __/ __/ ____

Address: ____

City: ___________________ State: ______ Zip Code: __________

Parent/ Guardian #1 Name & Cell Phone: ______________________________

Parent/ Guardian #1 Name & Cell Phone: ______________________________

Child Cell/Home/Phone: ______________________________

Parent Email: _______________________

Emergency Contact Information:

Name: _______________________________________ Phone: ___________________

Policy Holder's Information (complete only if insurance is being utilized):

~ PLEASE PRINT CLEARLY ~

Insurance Company: ____

Name: ______________________ Relationship to Client: __________________

Date of Birth: ___/___/_____ Social Security #: ______________________

Insurance ID: __________________ Insurance Group Number: ________________

Insurance Phone: _____________ Employer: ____________________________

Informed Consent for Counseling Services

This form is to document that I, ______________________________________ give voluntary consent to receiving counseling services from To Simply Live, Ryan Vogt-Foster MSW, LCSW.

Purpose and Background: The purposes, goals and treatment procedures of the counseling services to be provided will be explained to me upon request. Where appropriate I have also received information about the techniques and methods of treatment to be used by my counselor. I understand that my counselor is licensed in the state of KY to provide counseling services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise. While I expect benefits, I am aware that the practice of counseling is not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by To Simply Live, Ryan Vogt-Foster MSW, LCSW. Potential benefits, risks and limitations of counseling services have been explained to me, as well as alternative procedures or interventions if they exist.

Confidentiality: I understand that my conversations with my counselor will almost always be confidential. However, there are some important exceptions to this. I understand that he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but is not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

HIPAA: I understand that this consent form acknowledges my right to privacy and the limitations on my privacy; I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of "Notice of Privacy Practices", I acknowledge I was offered this policy statement on the date indicated by my signature below.

Attendance: I understand that regular attendance, a willingness to be open and honest and follow-through on treatment suggestions will produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to discontinue treatment at any time. ***I understand that if I need to cancel an appointment, I will need to call or text 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the "Full Fee" rate. Further, I understand that my insurance will not cover these***

charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24-hour) notice.

Contact Information: The office address for To Simply Live, Ryan Vogt-Foster MSW LCSW is 1655 Burlington Pike, Ste 218, Florence, KY 41042. Email address is as follows: ryankvogt@outlook.com. I understand that for routine appointments and information I may call or text (859)468-0793.. If I have an after-hours crisis or need assistance more quickly or in the event that I cannot reach my counselor, I understand that it is recommended that I call my primary care physician and/or 911 or go to the nearest emergency room.

*I certify, with my signature below that I have read, explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment."

Signature of Responsible Party : ______________________________ **Date:** ___/___/_____

Signature of Ryan Vogt-Foster MSW, LCSW:

Consent to Bill Third Party Payer

Use of Insurance: As a client of To Simply Live, Ryan Vogt-Foster MSW, LCSW, I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third-party payer, i.e., medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third-party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and may additionally constitute the release of treatment planning information.

Payment: I understand that payment is expected at the time of service. If I wish to pay for services out of pocket, or for the purposes of making my co-payment should I elect to use my insurance, I may make payments via cash, check (***made payable to: Ryan Vogt-Foster LLC***), credit or debit card. I understand all checks returned unpaid will be subject to a $30.00 service fee. If I have a balance due for more than three months, my account may be turned over to a collection agency for the purpose of recovering lost funds. Use of Insurance and Authorization for Treatment: If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral or not following necessary guidelines set by my insurance company for accessing mental health benefits. I understand I will be charged at full fee rate for missed or cancelled appointments unless notification is given 24 hours prior to the scheduled time of the appointment. I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.

I, ____,

____ wish to use my medical insurance to off-set the cost of treatment, and in so doing give my counselor permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my counselor any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.

____ do not wish to use any medical insurance benefit to cover services I receive through my counselor. I understand that I am financially responsible for all expenses incurred for my treatment and will make all payments at the time of service.

Signature of Responsible Party: ______________________________ **Date:** ___/___/____

Signature of Ryan Vogt-Foster MSW, LCSW: _Ryan Vogt-Foster MSW, LCSW_

THIS PAGE MUST BE COMPLETED PRIOR TO FIRST APPOINTMENT

Payment Authorization Form:

I, __________________________ authorize the following fees to be charged to the debit/credit card:

___ copay ___ deductible ___ full fee payments ___missed/late cancellation

This agreement serves as prior notification. Receipts will be provided via email.

Please complete the information below:

I ____________________________, authorize To Simply Live, Ryan Vogt-Foster LLC. to charge my credit card indicated below for counseling services as fees are incurred after 3rd party payers have processed charges for payment of all agreed-upon services provided including therapy, missed appointment/late cancellation fees (less than 24-hour notice), and all other fees detailed in the enclosed consent to bill.

Billing Address: ____ Phone: __________________

City, State, Zip: ________________________________ Email: _____________________

Debit/Credit Card (please print clearly)

_____Visa _____MasterCard _____ American Express _____Discover

Cardholder Name: ____

Account Number: ____

Exp. Date: ___/___/_____

SIGNATURE: ____ **DATE:** ___/___/_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify To Simply Live, Ryan Vogt-Foster MSW, LCSW in writing of any changes in my account information or termination of this authorization. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that To Simply Live Ryan Vogt-Foster MSW, LCSW may at her discretion attempt to process the charge again within 10 days, and agree to an additional $30 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

Child/Teen Questionnaire

What primary concern(s) do you have for your child?

____

____

____

How long has this been a problem?

____

____

What have you tried to do to resolve this/these issues?

____

____

What are your goals for counseling?

____

____

Previous Treatment History: (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency/use):

____

____

____

____

Who resides with you in your home (include child of focus)?

Name	Relationship to Child:	Age:
___________________________	_________________________	_______________
___________________________	_________________________	_______________
___________________________	_________________________	_______________
___________________________	_________________________	_______________
___________________________	_________________________	_______________
___________________________	_________________________	_______________

Who is primarily responsible for the daily care of your child? List all, including daycare:

Name:	Relationship:
___________________________________	__________________________
___________________________________	__________________________
___________________________________	__________________________
___________________________________	__________________________

What are the most common disciplinary techniques used in the household? (Verbal reprimands, yelling, ignoring, grounding, removal of privileges, spanking, etc...)

____

____

Circle the above method(s) most commonly used.

Are disciplinary techniques used consistently and with good follow-through?

By You? ___No ___Yes **By other parent?** ___No ___Yes

Are current disciplinary techniques effective at controlling undesirable behaviors?

___No ___Yes

Has your child experienced any of the following?

___Parental Divorce ___Death of Sibling ___Financial Problems

___Domestic Violence ___Sexual Abuse ___Parental Separation

___Death of Grandparent ___Parental Alcoholism ___Physical Abuse

___Family Bankruptcy ___Death of Parent ___Death of Close Friend

___Parental Drug Abuse ___Verbal Abuse ___Prolonged Marital Discourse

Has any member of your family ever been diagnosed with a mental illness or substance abuse problem including alcoholism? ___No ___Yes

If yes, please provide further details: ____

____

Was your child born premature? ___No Yes___

Birth Weight: __________ lbs. __________ oz.

Approximate age when your child first began:

Walking: __________ Talking: _________ Toileting: __________

Does your child have any chronic (long-term) health problems (asthma, seizures, allergies, etc.)? No___ Yes____

Has your child ever sustained any serious head injuries (unconscious, auto accident, fight, etc.)? No___ Yes____

Does your child have any developmental disorders (learning disabilities, hearing disabilities, speech problems, etc.)? No ___ Yes ___________________________________

Is your child currently under the care of a physician? ___No ___Yes

If yes, Doctor's Name: ____
Doctor's Phone: _________________________

Conditions being treated:

____

____

Is your child currently on any medication? ___No ___Yes

Medication	Dosage	Date Started
______________________________	___________________	____________
______________________________	___________________	____________

Please list all previous mental health medications:

Medication	Dosage	Date Started	Date Stopped
______________________________	___________________	______________	_____________
______________________________	___________________	______________	_____________
______________________________	___________________	______________	_____________

Please rate the nutritional value of your child's diet. Good ___ Fair___ Poor___

If fair or poor, please explain:

____

Check any of the following that apply:

___Significant weight gain/loss in last 6 months ___Problems chewing or swallowing

___Food/drug allergies ___Dieting ___Overeating or eating too little

If any box is checked please explain:

____

What grade is your child currently in?_______________

Where does your child attend school? ____

Teacher Name: ____

Circle any grade(s) failed. K 1 2 3 4 5 6 7 8 9 10 11 12 None

Circle any grades skipped. K 1 2 3 4 5 6 7 8 9 10 11 12 None

What grades does your child normally get in school? (Circle all that apply)

A B C D F

Have there been any tendencies toward improving or deteriorating school performance over the years? ___No ___Yes: If "YES" please provide further details.

____

____

What are your child's strongest subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies

What are your child's weakest subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies

Has your child ever been:

Served detention (even daycare): ___No ___Yes

Been suspended (even daycare): ___No ___Yes

Been expelled (even daycare): ___No ___Yes

If yes to any, please explain:

____

____

Has your child had psychological, educational, or psychometric testing? ___No ___Yes

If yes, describe results: (Please share any related documentation)

____

____

Describe your child's ability to make and keep friends:

____

____

What are the most common activities that your child engages in? (bike riding, playing with friends, TV, etc.)

____

____

Has your child ever been in trouble with the law? ___No ___Yes

If "YES", please explain.

____

____

To your knowledge, does your child used or tried tobacco? ___No ___Yes

To your knowledge, does your child drink or tried alcohol? ___No ___Yes

If yes, how often, how much, and for how long?

____

When was the last time? _____________________ How many drinks? _____

What problems has your child suffered as a result of his/her drinking?

___Arrest ___DUI ___Peer problems ___Public intoxication

___Financial problems ___Arguments ___None of the above

To your knowledge, has your child ever tried drugs? ___No ___Yes

If "YES" what drug(s)?

____

____

To your knowledge, does your child regularly us any drugs? ___No ___Yes

If yes, how often, how much and for how long?

____

____

When was the last use? ______________ What drug/s was used? ______________________

To your knowledge, is your child sexually active? ___No ___Yes

Do you or your child have concerns about his/her sexual orientation or sexual experiences? ___No ___Yes

Who currently has legal custody of your child?

Both parents___ Mother only___ Father only___ Other guardian: _________________

Has anyone else ever had legal custody of your child? _____________________________

How would you describe your relationship with your child?

____

____

____

How would you describe the other parent/guardian of the child?

____

____

____

____

Describe the relationship between you and the child's other parent/guardian.

____

____

____

____

Please describe anything else that you have not mentioned above that might be helpful in your child's treatment:

____

____

____

____

____

____

____

____

____

____

____

Signature and Date of person completing this form:

X____ ___/___/_____

~ Thank you for trusting in me ~

Ryan Vogt-Foster MSW, LCSW