To Simply Live

Ryan Vogt-Foster, LLC.
1655 Burlington Pike Suite 218
Florence, Ky. 41042
ryankvogt@outlook.com

Family Counseling Information Sheet:

Name: _____ Date: ___/___/____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Alternate Cell/Home/Work Phone: _____

Email: _____ SSN: _____ DOB: ___/___/_____

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 Client: _____ **Date:** ___/___/_____

Signature of Ryan Vogt-Foster MSW, LCSW: 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 Client/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.

Family Information

Mothers Name: _____ DOB: ___/___/____

Cell Phone: _____ Home/Alternate Phone: _____

Email address: _____

Occupation: _____

Fathers Name: _____ DOB: ___/___/____

Cell Phone: _____ Home/Alternate Phone: _____

Email address: _____

Occupation: _____

Parents Relationship status: Married____ Separated/Divorced____ Never Married____

Child's Name: _____ DOB: ___/___/____ Grade: _____

Child's Name: _____ DOB: ___/___/____ Grade: _____

Child's Name: _____ DOB: ___/___/____ Grade: _____

Child's Name: _____ DOB: ___/___/____ Grade: _____

If parents are not together what the current custody and time sharing arrangement:

_____

_____

How were you referred to this office: _____

What are you hoping to gain from therapy:

_____
_____
_____
_____

Patient/Family Assessment

In filling out this form you are welcome to provide as much information as you would like. If you find a question that you desire to leave blank, you are welcome to do so for any reason.

Presenting Problem:

Briefly describe the reason(s) for seeking therapy and the issues that need to be addressed:_____
_____
_____
_____
_____
_____

What do you think it would take to improve the situation?

_____
_____
_____
_____
_____

How have you tried to address the problem in the past? What have you tried and were the changes better worse?

_____
_____
_____
_____

Are you court ordered to seek therapy? Yes___ No___ (If yes please list agency, attorney, or probation officer's contact information/case#). _____

_____

Has there been a Friend of the Court or Guardian Ad Litem appointed: Yes___ No___

If yes, please provide their contact details:_____

Family Background

Please list other family members either living in the household or are significant in your child's life:

Name	Age	Gender	Relationship	Lives with (yes or no)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are there cultural or religious beliefs that are important to be aware of?
Yes or No If yes, please explain:_____

Please circle any past, present, or impending problems/stressors in the family:

Physical / Sexual / Emotional Abuse____ Isolation____ Deaths____ Divorce____

Financial/unemployment____ Frequent relocations____ Legal issues____

Emotional/Behavioral Concerns____ Health Concerns____ Alcohol/Drug Addictions____

Eating Disorders____ Suicide Attempts/Ideation____ Learning Disabilities____

High Conflict Relationships____

If yes to any of the above, for whom? _____

Please describe: _____
_____
_____
_____

Medical History

Please list any relevant medical problems or physical handicaps of family members:
_____
_____

Please list any previous therapy received by mental health professionals?
_____

Has anyone in the family ever been hospitalized for psychiatric reasons? Yes___ No___
If yes, please specify the details:

_____

_____

Has anyone in your family experienced any significant stressors or traumatic event?
Yes___ No___ If yes, when? _____

Nature of experience: _____

_____

_____

Please check the symptoms that anyone in the family is currently experiencing. Please indicate which family member you are referring, as well as duration, & severity.

Symptom - Sadness / Depression____ Suicidal Thoughts____ Sleep Problems____

Changes in Appetite____ Inability to Concentrate____ Obsessive Thoughts____

Anxiety / Tension____ Panic Attacks____ Memory Problems___ Impulsive Behaviors___

Anger or Violent Outbursts____ Social Isolation____ Strange Thoughts____

Stomach aches / Headaches____ Compulsive Behavior____ Phobias____

Who? _____ **How Long?** _____

Severity: Mild Moderate Severe

Who? _____ **How Long?** _____

Severity: Mild Moderate Severe

Who? _____ **How Long?** _____

Severity: Mild Moderate Severe

Who? _____ **How Long?** _____

Severity: Mild Moderate Severe

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature and Date of person completing this form:

X_____ ___/___/_____

~ Thank you for trusting in me ~

Ryan Vogt-Foster MSW, LCSW