Celeste Daiber, M.Ed., LPC-S, NCC, RPT
Independent Provider
Insight Professional Counseling, LLC
408 Jefferson Street
Saint Charles, MO 63301
636-724-1224
866-361-8832 (fax)

Adult Information Form

Today's Date: _____

Name: _____Date of Birth: _____Gender M___ F___

Address: _____City:_____ State:____ Zip:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Occupation: _____

Marital Status: □ Never Married □ Married □ Divorced/Separated

If married, spouse's name_____

Others in the home (grandparents, cousins, family friends):

Name/ Age/ Gender

1.

2.

3.

4.

Insurance: _____

Insight Professional Counseling, LLC
Celeste Daiber, M.Ed., LPC-S, NCC, RPT

Licensed Professional Counselor-Supervisor, Registered Play Therapist

408 Jefferson Street
St. Charles, MO 63301

Phone (636) 724-1224

Fax (636) 724-1226

Agreement for Confidentiality of Individual Treatment

I understand that it is Celeste Daiber's role to provide therapeutic services so that I might feel better and/or improve my functioning, both at home and at school/work, especially as it relates to my family. Ms. Celeste's role is not intended to gather information for the courts or to make judgments related to me, my child or my family. Ms. Celeste is not a forensic investigator, nor can be she used to fill that role for the courts.

Therefore, I agree that I will not call upon Ms. Celeste to provide treatment records or to testify in a future divorce, custody action or court proceeding. I understand that courts can appoint professionals who have had no prior contact with my child, myself or my family to conduct independent evaluations and make recommendations to the court.

I understand that it is Ms. Celeste's policy to have no court involvement in my/my child's case as that could harm our professional therapeutic relationship and the ability to achieve our goals. Our goals include resolving difficulties with my child and my entire family system/unit, and court involvement could impede progress. Since parties involved need to speak freely, my spouse is also agreeing never to ask Ms. Celeste to testify or have records of treatment subpoenaed in court.

If subpoenaed, by signing this form you are agreeing to an hourly fee of $400 per hour for any preparation time, travel, lost client time for court dates that are continued, waiting time and testifying time.

By signing this form we are both agreeing not to use any of my/my child's therapeutic intervention records or testimony in any current or future court proceedings.

Signed: _____Date_____

Signed: _____Date_____

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CLIENT INFORMATION AND CONSENT
Commitment to Therapy Contract

Welcome to my practice. I appreciate you giving me the opportunity to help you.
This packet answers some questions clients often ask about any therapy practice. It is important to me that you know how we will work together. Please read this carefully and sign. We will review this information during our first appointment. Feel free to ask any questions you may have regarding this form.

THERAPIST
I am a Licensed Professional Counselor in the State of Missouri.
I am engaged in private practice providing mental health services to clients directly and as an independent contractor/provider to many insurance companies.

COUNSELING SERVICES
I view therapy as a collaboration with you, with your child, and/or your family members (if they are part of the services) and myself. We will work together to develop a better understanding of your child, you, your goals and your values. Therapy may help you define areas for improving relationships, coping with stress or anxiety, enhancing communication and listening skills, or changing old behaviors and developing new ones. Working with a therapist can help provide support, insight, and new strategies to navigate through all types of challenges. It requires your best efforts to change thoughts, feelings or behaviors. It also requires that you observe some of your behaviors and practice some of the new skills that you will learn in our sessions. I might ask you to do exercises, interventions, keep records, or do other tasks to deepen your learning. We will develop a treatment plan of goals and areas that you would like to improve. Together, we will look at progress made and examine areas that need to be developed.

APPOINTMENTS
Appointments are made by calling the St Charles Office (636-724-1224) Monday through Friday between the hours of 9:00am and 9:00pm. Please call to cancel or reschedule at least **24 hours in advance**, or you will be charged for the missed appointment. Third party payments will not cover or reimburse for missed appointments. You will be expected to pay these charges out of pocket.

NUMBER OF VISITS
The number of sessions needed depends on many factors including but not limited to managed care or health insurance coverage, Employee Assistance Program (EAP) benefits, or treatment plan goals. These will be discussed during your sessions.

LENGTH OF VISITS
For clients using their mental health or EAP benefits, therapy sessions are now (as of 01/01/2013) 45 minutes in length. For those “fee-for-service” clients (opting to not use their mental health benefits) sessions are 45-50 minutes in length. A 60 or 75 minute session may be scheduled depending on need and insurance benefits.

WHAT TO EXPECT FROM OUR RELATIONSHIP

As a professional, I will use my best knowledge and skills to help you. This includes following the standards of the Missouri Department of Professional Registration regarding Licensed Professional Counselors. In your best interests, the Missouri Committee for Professional Counselors puts limits on the relationship between a therapist and a client and I will abide by them. These limits include the following:

• Our relationship is a professional and therapeutic relationship. In order to preserve this relationship, I cannot have any other role in your life. I am not in a position to be your friend or have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between us except in unusual circumstances.

• State and federal laws require me to keep what you tell me confidential. You can trust me not to tell anyone else what you tell me, except in certain limited situations. See the "Confidentiality" section of this handout. I try not to reveal who my clients are to maintain this confidentiality. If we meet on the street or socially, I will not initiate the conversation or talk very much. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

CANCELLATIONS

If you need to cancel an appointment, I require notification **at least 24 hours** in advance or you will be billed directly for the full cost of your missed session. If you are using insurance, you will be charged the **CONTRACTED RATE** for the cost of your missed session (e.g., if the contracted rate for United Health Care is $60/session, and your copayment is $25, you will be charged $60 for the missed session). You may leave a message on the voice mail, which does have a time stamp and is checked after regular office hours. In the case of sickness, notice **MUST** be given **before 9:00am** on the day of your appointment to avoid being charged.

When you schedule an appointment, I make a commitment to see you during that time, and you commit to pay for the time that I have reserved especially for you. If you miss more than three appointments in a row, or if canceling on short notice becomes habitual, I may choose to terminate our treatment relationship.

PAYMENT FOR SERVICES

Payment for services is an important part of any professional relationship. As of 1/1/15 my fee for service client rates are as follows:

• Initial evaluation - $120 for 60 minutes
• Psychotherapy - $100 for 45 minutes
• Psychotherapy - $120 for 60 minutes
• Family therapy - $100 for 45 minutes

You will be responsible for full payment of your account, and you will be responsible for payment of all charges. Full payment or copayment is expected at the time services are provided. Payment can be in the form of cash or check. A fee of $30 will be charged for all returned checks.

• ***Insurance and EAP Services:*** I accept insurance from most companies. The best way to find out if your insurance will pay for services is to look on the insurance company's website or call them and ask about what your plan specifically covers. You will need to give them my name and credentials when you call.

  - Different co-payments or co-insurance payments are required by various group coverage plans. Your co-payment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the co-payment may be different for the first visit than for subsequent visits. You may also be responsible for the contracted rate (as deemed by the insurance company) until all your yearly insurance deductibles have been met.

  - Prior to your first visit, you are responsible for checking your insurance and/or EAP benefits including coverage, deductibles, preauthorization, number of sessions permitted, payment rates, co-payments and co-insurance.

- Co-payments are collected at the time of service in the form of cash, check or credit card. If, at any point in time, a co-payment, statement or preauthorization has been adjusted, you will be notified. You will be required to pay the difference or will be given a credit if overbilled. I will make you aware of any credits or adjustments from the insurance company. If your insurance does not pay for services, you will be responsible for the balance due.

• ***Telephone consultations:*** Telephone consultations may be needed at times in our therapy. Insurance does not pay for telephone consultations. Direct telephone contact over 10 minutes will be billed on a prorated basis at $2.00 per minute. If I need to have long telephone conferences with other professionals as part of your or your family's treatment, you will be billed for these at the same rate as regular therapy services. There is no charge for calls about appointments or similar business.

• ***Reports:*** I will not charge you for my time spent making routine reports to the insurance company. I will charge you for my time for any reports made to schools, attorneys, courts or physicians.

• ***Other Services:*** Charges for other services, such as hospital visits, consultations with other therapists (beyond 10 minutes), or any court-related services (such as consultations with attorneys, depositions, or attendance at courtroom proceedings) will be based on the time involved in providing the service at my regular fee schedule. Some services may require payment in advance.

CONFIDENTIALITY

Sessions between a therapist and a client are both privileged and confidential. No information will be released without the client's written consent unless mandated or permitted by law or unless necessary or permitted by professional ethics, state law, and federal regulation (HIPAA). Examples of circumstances when information about our sessions may be released include:

1. mandatory legal obligation, such as child abuse or elder abuse;
2. court subpoena, cooperating with law enforcement officers, under certain circumstances;
3. suspected personal danger to yourself or an identified victim;
4. information required by insurance companies for payment (for which you consented);
5. information provided to parents, if client is a minor;
6. consultation with other professionals in order to aid in the counseling/treatment process (identifying information will be withheld unless written permission is given);
7. to defend myself against a claim of improper care.
8. information provided to a collection agency or attorney for collection of unpaid amounts owed as a result of services provided for client.

• Release of information to other individuals, agencies or professionals other than what is covered in this section may be permitted only with your written consent.
• Additional policies pertaining to HIPAA are described in the "Notice of Privacy Practices."
• When meeting with couples, in order to provide the safest environment possible, it is my policy not to release information for divorce proceedings if they may ensue. When you sign this disclosure, you are agreeing not to subpoena my records in order to defame the character of your spouse in the process of a divorce, except in cases of clear, observable abuse that I have personally witnessed.
• In order to provide you with the highest quality service possible, I consult regularly with other professionals about my work with clients. All names and identifying information will be changed and kept private.
• I keep all adult records for seven years after the last date of service. All records for children under 18 are kept for seven years after they turn 18. After that, they are shredded to protect your confidentiality.
• An insurance company will sometimes request information on symptoms, diagnoses, and treatment methods. This information will become part of your permanent medical record. I will inform you should this occur.

Client Informed Consent

Please initial each item to indicate that you have read and understand it.

DUTY TO WARN

In the event that the undersigned therapist believes that I, the client, am in danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person(s) in danger and to **contact the following persons**, in addition to medical and law enforcement personnel:
Contact Name: _____ Phone number: _____
Relationship: _____
Contact Name: _____ Phone Number: _____
Relationship: _____
Initial _____

RISKS OF THERAPY

Therapy is the Greek word for change. As the client, you may learn things about yourself that you may not like. Often, growth cannot occur until you experience and confront issues that may make you feel sad, sorrow, anger, anxiety or pain. There is a risk that clients will experience uncomfortable feelings. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Sometimes, a client's problems or child's behavior may temporarily worsen after the beginning of treatment. Even with our best efforts, there is a risk that therapy may not work out well for you.
I, the client, understand that no guarantees have been made to me as to the results of treatment or of any procedures provided by my therapist. I am assured that the therapist will not perform any services that are in violation of the code of professional responsibilities which govern this profession.
Initial _____

AFTER HOURS EMERGENCIES

I, the client, understand that the undersigned therapist does not focus on crisis counseling and expects her clients to be able to keep themselves safe. In case of an emergency and I am unable to reach the therapist, I can contact Life Crisis Services at (314) 647-4357, Behavioral Health Response [314] 469-6644, dial 911 or go to the nearest hospital emergency room.
Initial _____

WAIVER OF FULL DISCLOSURE

I, the client, have been advised that I have a right to copies of my entire file but acknowledge that some information may not be in my best interest to review. In the event my therapist, in the exercise of her professional judgment, determines that information in my file is injurious to me, **I, the client, waive my right** to obtain such potentially injurious information and release my therapist from any and all such claims, damages and causes of action that I suffer or could assert for her refusal to provide me with the information requested.
Initial _____

THERAPIST'S INCAPACITY, DEATH, OR RETIREMENT

I, the client, acknowledge that in the event that the undersigned therapist becomes incapacitated, dies or retires it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allow another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.
Initial _____

CONSENT TO TREATMENT

I, _____ (name of client), voluntarily, agree to receive mental health assessment, care, treatment, or services, and authorize my therapist, Celeste Daiber, M.Ed., LPC-S, NCC, RPT of Insight Professional Counseling, LLC to provide such care, treatment, or services as are considered necessary and advisable. I understand that I will participate in the planning of my care, treatment, or services.
I am aware that I may discontinue care, treatment or services with my therapist at any time.
I understand that no guarantees have been made to me as to the results of treatment or of any procedures provided by my therapist.

BY SIGNING THIS CLIENT INFORMATION AND CONSENT FORM, I, THE UNDERSIGNED CLIENT, ACKNOWLEDGE THAT I HAVE BOTH READ (OR HAVE HAD READ TO ME) AND UNDERSTOOD ALL THE TERMS AND INFORMATION ABOUT THE THERAPY SERVICES THAT I AM RECEIVING. I HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

Release of Liability
I, do for myself and assigns hereby and unconditionally, release and discharge Celeste Daiber, M.Ed., LPC-S, NCC, RPT of Insight Professional Counseling, LLC and their employees heirs and assigns, jointly and severally from any action, suit, claim, or demand I have or may ever have against them due to my participation in therapy performed by them.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist **Date**

___ Copy accepted by client **____ Copy kept by therapist**

Revised 12/16

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Notice of Privacy Policies

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES
HOW INFORMATION ABOUT YOU MAY BE DISCLOSED,
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, this counselor will disclose no information about you [or your child], or the fact that you [or your child] are my patient, without your written consent. This counselor's formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, this counselor does not routinely disclose information in such circumstances, so this counselor will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting this counselor.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by this counselor's choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from this counselor, you must sign the attached form indicating that you understand and accept this counselor's policies about confidentiality and its limits. We will discuss these issues now if you choose, and you may reopen the conversation at any time during our work together.

This counselor may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, this counselor will share information if it seems to be necessary and appropriate for your medical treatment.

· Child Abuse Reporting: If this counselor has reason to suspect that a child is being abused or neglected, this counselor is required by Missouri law to report the matter immediately to the Missouri Department of Social Services.

· Adult Abuse Reporting: If this counselor has reason to suspect that an elderly or incapacitated adult is being abused, neglected or exploited, this counselor is required by Missouri law to immediately make a report and provide relevant information to the Missouri Department of Welfare or Social Services.

· Health Oversight: Missouri law requires that licensed professional counselors report misconduct by a health care provider of their own profession. By policy, this counselor also reserves the right to report misconduct by health care providers of other professions. [For Counselors: Missouri law requires that licensed counselors report misconduct by any mental health care provider.] By law, if you describe unprofessional conduct by another mental health provider of any profession, this counselor is required to explain to you how to make such a report. If you are yourself a health care provider, this counselor is required by law to report to your licensing board that you are in treatment with me if this counselor believes your condition places the public at risk. Missouri Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and this counselor will not release information unless you provide written authorization or a judge issues a court order. If this counselor receives a subpoena for records or testimony, this counselor will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, this counselor is required to place said records in a sealed envelope and provide them to the Clerk of Court. In civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Missouri has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if this counselor does an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

· Serious Threat to Health or Safety: Under Missouri law, if this counselor is engaged in her professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death to an identified or to an identifiable person, and this counselor believes you have the intent and ability to carry out that threat immediately or imminently, this counselor is legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under the age of 18, 2) notifying a law enforcement agency or officer, or 3) seeking your hospitalization. By policy, this counselor may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, this counselor can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or law enforcement officer, whether you are a minor or an adult.

· Public Health Risks - We may disclose medical/health information about you for public health activities. These activities usually include the following: 1) to prevent/control disease/injury/disability, 2) to notify a person who may have been exposed to a disease/may be at risk for contracting/spreading a disease or condition; or 3) to notify the appropriate government authority if we believe a client has become a victim of abuse or neglect/domestic violence- in this category, we will only make disclosure if you agree or when required or authorized by law.

· Workers Compensation: If you file a worker's compensation claim, this counselor is required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· Records of Minors: Missouri has a number of laws that limit the confidentiality of the records of minors. Other uses and disclosures of information not covered by this notice or by the laws that apply to this counselor will be made only with your written permission.

HIPPA Rules permit use and disclose of protected health information purposes not otherwise permitted by the Rule if it has obtained a valid written authorization from the individual who is the subject of the information. Two specific circumstances in which authorization from the individual must be obtained are (1) Most uses and disclosures of psychotherapy notes; and (2) uses and disclosures for marketing purposes.

HIPPA Rules permit us to use or disclose only demographic information relating to the individual and dates of health care provided to the individual for fundraising communications.

HIPPA Rules prohibit (except in certain allowable circumstances) us from receiving direct or indirect remuneration in exchange for the disclosure of protected health information unless we have obtained an individual's authorization that states whether the protected health information can be further exchanged for remuneration by the entity receiving the information.

HIPPA Rules set forth certain circumstances in which we now must comply with your request for restriction of disclosure of your protected health information. Specifically, we must agree to the requested restriction unless the disclosure is otherwise required by law, if the request for restriction is on disclosures of protected health information to a health plan for the purpose of carrying out payment or health care operations and if the restriction applies to protected health information that pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full.

HIPPA Rules require that if you request an electronic copy of protected health information that is maintained electronically, we must provide you with access to the electronic information.

HIPPA Rules permits us (if we have that information and if we have oral or written authorization to do so) to disclose proof of immunization to a school where State or other law requires the school to have such information prior to admitting the student.

HIPPA Rules require us to protect the privacy of a decedent's protected health information generally in the same manner and to the same extent that is required for the protected health information of living individuals.

III. Patient's Rights and Provider's Duties:

· Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information this counselor discloses about you to someone who is involved in your care or the payment for your care. If you ask this counselor to disclose information to another party, you may request that this counselor limits the information disclosed. However, this counselor is not required to agree to a restriction you request. To request restrictions, you

must make your request in writing, and tell this counselor: 1) what information you want to limit; 2) whether you want to limit use, disclosure or both; and 3) to whom you want the limits to apply.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing this counselor. Upon your request, this counselor will send your bills to another address. You may also request that this counselor contact you only at work, or that this counselor does not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, this counselor will discuss with you the details of the accounting process

. · Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, this counselor may charge a fee for costs of copying and mailing. This counselor may deny your request to inspect and copy in some circumstances. This counselor may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information this counselor has about you is incorrect or incomplete, you may ask this counselor to amend the information. To request an amendment, your request must be made in writing, and submitted to this counselor. In addition, you must provide a reason that supports your request. This counselor may deny your request if you ask to amend information that: 1) was not created by me; this counselor will add your request to the information record; 2) is not part of the medical information kept by this counselor; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Changes to this notice: this counselor reserves the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information this counselor already has about you as well as any information this counselor receives in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. Copies of the current notice are available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to this counselor's office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: _____

Name: _____

Revised 10/2014