Insight Professional Counseling, LLC
Celeste Daiber, M.Ed., NBCC, LPC-S, RPT-S
Licensed Professional Counselor-Registered Supervisor, Registered Play Therapist-Supervisor
National Board Certified Counselor, EMDRIA Certified Therapist
408 Jefferson Street
Saint Charles, MO 63301
Phone (636) 489-1822 Fax (866) 361-8832

Child/Adolescent Intake Information Form

Today's Date: _____/____/_____ Completed by: □ Mother □ Father □ Other_____
Name of client: _____Date of Birth: ____/____/_____
Gender: □ Male □ Female □ Other: please state how you would like to identify: _____
Address: _____
City/State/Zip_____
Home Phone: _____ Can a message be left? Yes / No [circle one]
Cell Phone: _____ Can a message be left? Yes / No [circle one]
Mother's/Guardian's Name: _____
Address: _____
City/State/Zip_____
Home Phone: _____Work Phone: _____
Cell Phone: _____ Can a message be left? Yes / No [circle one]
Email:_____
Occupation:_____
Father's/Guardian's Name: _____
Address: _____
City/State/Zip_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Can a message be left? Yes / No [circle one]
Email: _____
Occupation: _____
Parents' Marital Status: [ ] Single [ ] Married [ ] Divorced/Separated [ ] Widowed
If divorced, who is legal guardian? Has physical custody [sole/shared]? Medical decisions [sole/shared]?
_____
[Please provide supporting paperwork/court records or orders/copies of divorce and/or custody decree]
Siblings (including step-siblings and half-siblings):
Name/ Age/ Gender
1.
2.
3.
4.
5.

Others in the home (grandparents, cousins, family friends):
Name/ Age/ Gender
1.
2.
3.
4.

All other persons living in the home with the child/adolescent currently [other than above]:

Referral source: [how did you find out about Ms. Celeste?] [circle one] Friend / Family / School / Physician / Facility / Agency / Insurance website provider list

Your insurance company provider is:

_____

ID Number:_____Group Number_____

Please note:

It is the insured cardholder/member's responsibility to verify in-network behavioral health coverage services, plan, deductible amounts and benefits.

Should your insurance provider coverage change, it is the cardholder/member's responsibility to verify in-network behavioral health coverage services, deductible amounts and benefits, and inform your provider. Failure to verify will incur full private-pay fees.

Significant Life Events in the last two years:

□ Death of a loved one □ Divorce/Separation □ Move/School change □ Medical Problems for any family member
□ Financial problems for the family □ Legal problems for the family (assault, DUI/DWI, etc.)
□ Parental remarriage/new step-siblings □ Birth of a new sibling □ Trauma (violence, natural disaster, car accident, surgery, etc.)
□ Other _____

Child's Strengths or Abilities:

□ Academics/grades □ Sports □ Creative (art or music, etc.) □ Hobbies/interests □ Group involvement (clubs, organizations) □ Religious involvement □ Sense of humor □ Care for others

Other:

_____

_____

Current Concerns: [check all that apply]:

□ Behavior at home/school □ Mood □ Eating □ Sleeping □ Suicidal thoughts □ Academic performance/grades
□ Anger/Irritability □ Difficulty paying attention □ Peer relationships □ Health □ Drugs/alcohol □ Sexual behavior
□ Frequent worries/shyness □ Sensitive to touch, sound, light, motion, textures

Comments:_____

_____

Is there a history of any previous treatment or evaluations [IQ, ASD, LD, OT, Speech, Brain Mapping, etc.]?

□ Yes □ No

If so, when and by whom? Please provide copies if available.

_____

□ Educational evaluation [Including but not limited to IEP/Section 504 Plans]:

_____

□ Psychological evaluation: [When?]

_____

□ Intensive Outpatient Programming [IOP]: [Where?] [When?]

_____

□ Intensive Inpatient Hospitalization(s):

_____

Does your child take medication? □ Yes □ No

If so, please list medication(s) and dosage(s): [psych meds only]_____

_____

_____

Who is the prescribing physician?

Dr. _____

Medical History:

□ Medical problems during pregnancy □ Maternal drug or alcohol use during pregnancy
□ Premature birth (if so, weight at birth: _____gestational age: _____)
□ Complications during birth (ex. Emergency C-section, low oxygen, etc.)
□ Stayed in neonatal intensive care unit [NICU] (if so, how long? _____)
□ Health problems as a newborn or toddler □ Frequent ear infections □ Asthma or allergies
□ Head injuries/concussions/seizures/fevers over 104 degrees □ Serious accidents/hospitalizations
□ Surgeries □ Problems with eating or sleeping

Comments: _____

_____

Child's Developmental History problems or delays with:

□ Sitting up □ Walking □ Talking/Speech □ Toileting/toilet training □ Bedwetting

□ Writing letters or using scissors □ Reading or letter identification

□ Physical coordination (running, jumping, climbing) □ Responding to discipline or behavior management

□ Anger/temper tantrums □ Meltdowns □ Fears □ Sexual play

Other:_____

_____

_____

_____

Child's Academic History [Current]

School:_____

School location: _____ Grade: _____

Teacher(s):_____

□ Repeated a grade □ Skipped school □ Been suspended [ISS/OSS] □ Been expelled

□ Stopped doing homework □ Been bullied by others □ Been aggressive at school

□ Received an IEP or Section 504 Plan

□ Received any special services (OT, PT, DT, Reading, Speech, Math, Self-Contained classroom, etc.)

_____

Child's Social Relationships Does your child have a friend or friends outside the family? □ Yes □ No

Do you know them? □ Yes □ No

Do his/her friends tend to be: □ older □ younger □ about the same age as your child

How well does your child get along with others?

_____

_____

_____

Family History

Has anyone in your family struggled with (treated or untreated):

□ Depression □ Bipolar Disorder □ Anxiety □ Learning problems (reading, math, spelling, telling time, etc.)

□ Attention problems □ Alcohol or drug/substance use/abuse

□ Sexual abuse □ Physical abuse □ Suicide [attempts or completed]

Do you have any other concerns about your child/adolescent?

_____

_____

_____

_____

_____

_____

_____

_____

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Agreement for Confidentiality of Individual Treatment

I understand that it is Ms. Celeste role to provide therapeutic services so that I might feel better and/or improve my functioning, both at home and at school/work, including 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 she 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 document, we are all agreeing not to use any of my/my child's adolescent's therapeutic intervention records or testimony in any current or future court proceedings.

Signed: _____Date_____

Signed: _____Date_____

Signed: _____Date_____

Signed: _____Date_____

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Adolescent Informed Consent Document

Privacy of Information Shared in Counseling/Therapy:
Your Rights and My Policies

What to expect:
The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. You may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these issues. I will ask questions, listen to you, and suggest a plan for improvement. It is important that you feel comfortable talking to me about the things that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of effective counseling.
As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information.

There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by state and/or federal law or by the ethics guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.
- You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.
- You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- You tell me you are being abused - physically, sexually or emotionally - or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Missouri Department of Social Services.
- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written consent or agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

You should also know that, by law in Missouri, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you, or help with problem solving. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

For parents: Communication as delineated above is, at times, necessary. Letter-writing, written communication and phone calls do take time and there is a nominal fee for such services.

By signing this document, [sig page below] you agree to compensate your therapist for this time.

* * * * *

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Adolescent Consent Form & Parent Agreement to Respect Privacy Document

Adolescent counseling client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature: _____ Date_____

* * * *

Parent/Guardian:

Initial boxes and sign below indicating your agreement to respect your adolescent's privacy:

__/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

__/ Although I know I have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

____/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Therapist Signature _____ Date_____

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CLIENT INFORMATION AND CONSENT
Commitment to Therapy Contract

Welcome to my practice. I appreciate you have given me the honor and opportunity to help you.
This document 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. Please ask any questions you may have regarding this form.

THERAPIST
I am a Licensed Professional Counselor-Registered Supervisor in the State of Missouri.
I am engaged in private practice providing behavioral health services to clients.
I am an independent contractor/provider to several insurance companies.

COUNSELING SERVICES
I view therapy as a collaboration with you, with your child/adolescent, 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/adolescent, 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 problematic behaviors and developing new ones. Working with a therapist can help provide support, insight, growth, and new strategies to navigate through all types of challenges. It requires your best efforts to make yourself aware of your thoughts, feelings or behaviors in order to raise your level of functioning. 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 about yourself and things that might help. 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 weekdays between the hours of 9:00am and 5:00pm at 636-489-1822. Please call to cancel or reschedule **at least 24 hours in advance**, or you will be charged for the missed appointment. Third party payments/insurance will not cover or reimburse for missed appointments. You will be expected to pay these charges out of pocket. A valid credit or debit card is required to be on file at all times in case this should occur.

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 programming plan goals. These will be discussed during your sessions.

LENGTH OF VISITS
For clients using their behavioral/mental health in-network or EAP benefits, therapy sessions are dictated by insurance service code. For those "fee-for-service" clients opting to not use their insurance mental health or out-of-network benefits, sessions are 45-53 minutes in length. A 60- or 75-minute session may be scheduled depending on need, and may require prior authorization from your insurance provider.

WHAT TO EXPECT FROM OUR RELATIONSHIP

As a professional, I will use my education, training, knowledge, and skills to help you. This includes following the standards and ethics 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/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 document. 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

When you book your appointment with your provider, you are holding space on their calendar that is no longer available to our other clients. In order to be respectful of your fellow clients, please call or email as soon as you know you will not be able to make your appointment. It is understood that cancellation or rescheduling is sometimes necessary. In such case, it's required that you contact us at least 24 hours in advance. Appointments are in high demand, and your advance notice will allow another patient access to that appointment time.

Late Cancellations/No-Shows

An appointment is considered a late cancel when a client reaches out less than 24 hours before the scheduled appointment time. An appointment is considered a no-show when a client misses an appointment without cancelling ahead of time. In either case, we will charge $100.

Third party payments or private insurance will not cover or reimburse missed appointments. You will be expected to pay these charges out of pocket. A valid credit or debit card will be required to be on-file at all times for such occurrences.

For new patients' first appointments, a no-show or late cancellation will result in a charge of $100, and rescheduling will be at your therapist's discretion.

In case of Sickness or Emergency

In case of sickness, notice must be given before 9:00am on the day of your appointment to avoid a late cancel charge. Emergencies or extenuating circumstances will be addressed at your therapist's discretion.

If you miss or cancel more than three appointments in a row, or if canceling on short notice becomes habitual, it may be in both you and your provider's best interests to terminate the therapeutic treatment relationship. Referrals will be given upon request.

How to Cancel Your Appointment

If you need to cancel your appointment, please call or text the office at 636-489-1822 or email [celeste@celestedaiber.com]. If necessary, you may leave a detailed voicemail message. We will return your call or email as soon as possible.

PAYMENT FOR SERVICES

Payment for services is an important part of any professional relationship. As of 1/1/21 my fee-for-service [private pay] 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 unless other arrangements are made prior to your first session. Payment can be in the form of credit card, cash or check. A fee of 3.5% will be charged for credit/debit card processing and $35 will be charged for all returned checks.

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

- 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.

- 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, which may be handled by a different insurance company than your medical insurance policy. 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 deductible(s) have been met.

- 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, for any reason, your insurance does not pay for services, you will be responsible for the entire balance due.

Telephone consultations: Telephone consultations may be needed at times in our course of 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.

Text messaging: I give permission to have Insight Professional Counseling, LLC to send me SMS/text messages in communicating with me including for appointment scheduling and confirmation, general messaging and referrals to other professionals when appropriate. You may opt out of receiving text messages at any time by sending a "STOP" text. You may also send a "HELP" message if you have questions about Insight Professional Counseling, LLC services.

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:

- mandatory reporter legal obligation, such as child abuse or elder abuse
- court subpoena, cooperating with law enforcement officers, under certain circumstances
- suspected personal danger to yourself or an identified victim
- information required by insurance companies for payment (for which you have consented)
- information provided to parents, if client is a minor
- consultation with other professionals in order to aid in the counseling/treatment process (identifying information will be withheld unless written permission is given)
- to defend myself against a claim of improper care
- 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* document.

❖ 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.

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CLIENT INFORMATION AND CONSENT
Commitment to Therapy Contract
signature page[s]

Client Informed Consent

Please initial each item below 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 sadness, 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/adolescent'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 clients to be able to keep themselves safe. In case of an emergency outside of business hours 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 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 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 programming, or services, and authorize my therapist, Celeste Daiber, M.Ed., LPC, RPT-S, NBCC, 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, LPC, RPT-S, NBCC, 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 1/1/23

Insight Professional Counseling, LLC
Celeste Daiber, M.Ed., NBCC, LPC-S, RPT-S
Licensed Professional Counselor-Registered Supervisor, Registered Play Therapist-Supervisor
National Board Certified Counselor, EMDRIA Certified Therapist
408 Jefferson Street
Saint Charles, MO 63301
Phone (636) 489-1822 Fax (866) 361-8832

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.

Signature: _____

Revised 1/1/2023