Intake Packet

Consent for Treatment

I, _____ DOB: _____ hereby apply for Services from the

Behavioral Health Department of Resilience Counseling Services LLC.

Please Read Carefully

Psychotherapy is a working cooperative relationship between myself and my provider. Each member of this cooperative relationship has certain responsibilities.

My provider will contribute their knowledge, expertise, and clinical skills

I, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process.

While there are no guarantees regarding the outcome of the treatment, my commitment may increase the likelihood of a satisfactory experience.

Client Confidentiality

Communication between me and my provider is confidential. This means that my provider will not discuss my case orally or in writing without my expressed written permission.

My counselor has an ethical and legal obligation to break confidentiality under the following circumstances. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.

If there is reason to believe that I have serious intent to harm myself, someone else, or property by a violent act that I may commit.

The presence of surveillance cameras may be on the premises; I understand the usage of surveillance is not to infringe upon my rights to privacy and confidentiality but is used for added security measures to monitor the premises. I have been informed that only the CEO and/or their delegates will have access to the surveillance, which is maintained within the Agency and will be kept for a period of no longer than one year.

Responsible Party Confidentiality

Information will be maintained confidentiality under HIPAA policy unless the following occur:

• If a legal guardian provides written consent for information to be exchanged and received with a specified third party.

• If a legal guardian suspects that there is a plan to cause harm to self or others. Proper authorities will be informed if deemed appropriate by a clinician; this may include law enforcement, school and/or endangered person, if identified.

• If the dependent reports that there are thoughts of harm to self or others, the clinician will utilize professional judgment to determine whether the guardian is to be notified.
• If the dependent reports that current or past sexual abuse is or has occurred, by law, the clinician will report the abuse to the Cabinet for Health and Family Services, Department for Community Based Services, Division of Protection and Permanency.

Provider Availability

Resilience Counseling Services LLC is an outpatient practice in which providers are available during normal business hours. Providers check voicemail messages during normal business hours.

• Messages left outside of normal hours of operation will be returned the next business day.

• If I have an emergency that needs immediate attention I need to seek assistance at the nearest emergency services department.

Resilience Counseling Services Mandatory Crisis Plan

All Clients are required to sign a Crisis Response Plan. This is a state requirement.

In the event of a crisis, I agree to take the following steps:

• I will try to identify specifically what is upsetting me.

• I will write out and review more reasonable responses to this crisis or suicidal thoughts, including thoughts about myself, others and the future.

• I will review all conclusions about these thoughts in my treatment log or journal. (For example, The abuse was not my fault and I have nothing to be ashamed of.)

• I will try to do the things that help me feel better for at least 30 minutes. (For example, taking a walk, listening to music, calling my friend or other person in my support system.)

• I will repeat the above steps at least 1 time.

• If this crisis or suicidal thoughts continue, and I find myself preparing to act in a way that could bring harm to myself or others, I will call the emergency person identified on my crisis plan.

• If I still feel like I cannot control my actions, I will go to the nearest emergency room or call 911.

Additional Information

I understand that the services provided are therapeutic in nature to assist with concerns of emotional and behavioral health By signing this document I am stating that I understand and/or agree to each of the following:

• While in therapy there is a risk that symptoms may increase as these issues are dealt with. I will have a treatment plan that is created with their participation as well as the guardian's participation (if applicable).

• This plan will be followed and reviewed throughout therapy. Therapies used during treatment may vary and may include play therapy, cognitive-behavioral therapy, reality therapy, etc. I have a right to request a change in the method provided.
• I also have a right to request a change of therapist or agency at any time during my or my child's treatment. I and/or my child will take an active, cooperative role in the counseling process, but I understand that no specific outcomes are guaranteed.

• I understand that Resilience Counseling Services LLC is not liable for how I respond to or utilize information presented during counseling sessions.

• I and/or my child is responsible for following through on treatment goals, objectives, and therapy techniques developed and agreed upon in session.

• I will never be discriminated against based on religion, race, sex, or disability.

• It is my responsibility to keep appointments and follow the treatment plan, or services may be terminated.

• In the event the sessions are terminated, Mindsight clinicians will make appropriate referrals if they conclude that my needs may be met through other qualified professionals.

Case Management Services - Informed Consent

I, the undersigned, hereby apply for targeted case management services with Resilience Counseling Services LLC. (If you are applying on behalf of a minor, please write your relationship to the client).

I understand that the Targeted Case Management department is operated by staff that are certified to provide targeted case management in the state of Kentucky. I further understand that these staff are supervised by licensed or certified professionals on a weekly basis and may share information about my services with this person for the purpose of obtaining advice or clarification about appropriate treatment and service provision to meet the ongoing needs of myself/client. I understand that by participating in this service, there are minimum service requirements the targeted case manager must adhere to in order to meet regulatory requirements.

I give permission for the targeted case manager to contact me or the client face-to face at least two times per month. In addition, I grant permission for making two other indirect or direct contacts with any other treatment team member identified by the team as needing to be involved. I understand that these services, offered to me at no charge, will be discontinued if regular contact with TCM is not maintained, as this is a Medicaid requirement.

Discontinuing Services

In addition to my right to confidentiality, I have the right to end my counseling at any time, for whatever reason and without any obligation, with the exception of the payment of fees for services already provided.

I have the right to question any aspect of my treatment with my provider.

I also have the right to expect that my provider will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with me.

Resilience Counseling Services LLC reserves the right to discontinue counseling at any time including, but not limited to, a violation by me of this Consent for Treatment, a change or reevaluation by Resilience Counseling Services LLC of my therapeutic needs, Resilience Counseling Services LLC's ability to address those needs, or other circumstances that lead Resilience Counseling Services LLC to conclude in its sole and absolute discretion that my counseling needs would be better served at an another counseling facility. Under such circumstances, Resilience Counseling Services LLC will suggest an appropriate provider or counseling agency.

Notice of Privacy Practices-HIPAA

This notice describes how my health information may be used and disclosed and how myself or others can obtain access to this information.

This notice of Privacy Practices is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1995. Any information coming into the possession of Resilience Counseling Services LLC, is covered by this act. Any information requested by Resilience Counseling Services LLC, will be relevant to the care and well-being of the individuals served. All the information shall be considered Protected Health Information (PHI).

My signature on this Privacy Notice shall serve as acknowledgement that I have been informed about Resilience Counseling Services LLC, privacy practices. Additionally, my signature gives Resilience Counseling Services LLC, permission to use and share information necessary for treatment and collection efforts only (i.e. clinical supervision, quality assurance reviews, communications with billing staff). The use or sharing of any information not directly related to these services and supports shall have prior written authorization. An example of information sharing that may be necessary, without written consent or authorization is a life threatening medical emergency.

Rights of the Individual

I, in writing, may request restrictions on the use or sharing of information, receive confidential communication, inspect and receive copies of any shared information, receive an accounting of shared information and amend or revoke the authorization.

Duties of Resilience Counseling Services LLC

Resilience Counseling Services LLC, will maintain the privacy of my Protected Health Information, provide information about privacy practices, provide notice of legal duties regarding privacy practices, abide by this effective notice and any restriction agreements that are established, and provide notice of any revised privacy practices.

For additional information or complaints regarding privacy practices contact Resilience Counseling Services LLC, Privacy Officer, Tracy McQuarter at 606-485-4049

I have read or been read the Privacy Practices of Resilience Counseling Services LLC, and have received a copy. I understand all components of it and have had all questions answered by a staff member.

Cancellations

• If I am unable to keep my appointment, please cancel as soon as possible.

• According to Resilience Counseling Services LLC I must give at least 24 hours notice to cancel an appointment

• If I cancel my appointment with less than 24 hours notice, or I fail to show for a scheduled appointment, I will be charged a $50.00 fee.

• If I must cancel an appointment due to illness or emergency, I contact Resilience's office at least 24 hours before the scheduled appointment. Resilience staff will ask for my availability to reschedule the appointment. I will have several dates and times ready.

• When an appointment is rescheduled, it is expected that I will attend that appointment. Multiple cancellations require reviewing the schedule and determining if another time may be more beneficial.

• Please verify with staff any appointments that will be canceled due to vacation. Resilience Counseling Services LLC is unable to hold any time slot more than 2 consecutive weeks.

• In the event of inclement weather that may be a safety concern, I will contact Resilience's office if I am unable to make it to the appointment. A fee will not be assessed and a reschedule or Telehealth will be offered.

• Frequent canceled appointments (two cancellations within a 12 week period) can result in my discharge.

No Shows

• Failure to cancel or appear to an appointment is considered a no show. A full session fee will be assessed. Full session fees vary between clinicians and services scheduled, but are in the range of $100-$250 per missed appointment.

• I will contact Resilience's office immediately to discuss future appointments. If Resilience Counseling Services is unable to reach me within 48 hours after a no show appointment, my appointment time will be automatically offered to another client waiting for services.

• Two no show appointments within a 12 week period can result in a discharge.

Rescheduling

• Even with 24 hours notice, it is dependent on the provider's availability but it may not be possible to have a session in the same week

• I am encouraged to cancel or request appointment changes as soon as possible

• My copays or payments must be paid prior to services

• Resilience Counseling Services LLC reserves the right to suspend services if services are rendered and not paid for

A Note from Clinicians

When my provider establishes a Treatment Plan of Care for me, they base the goals and progress shared with the insurance company on having consistent therapy sessions. If I miss appointments or arrive late, it is more difficult to meet goals, and I will likely need to be enrolled in therapy for a longer period of time. In the event that I do have to cancel, it is strongly encouraged that I try to reschedule as soon as possible.

Fees

If I am using insurance benefits:

• Resilience Counseling Services will bill my insurance for my session. If I have Medicaid I will not be charged for my session. • Co-pays MUST be paid prior to session or at session. Accepted forms of payment are debit card, credit card, check or cash. • Accounts must be kept current in order to remain being seen by a clinician.

• If I am using my insurance benefits and have not met my yearly deductible, I will be required to pay the full contracted rate

Service Type	Service Fee
Individual Therapy Session	$200
Family Therapy Session	$250
Marital Therapy Session	$250
Mental Health Assessment	$150
Substance Abuse Assessment	$150
Parenting Assessment	$300 ($150 per session, requires 2 sessions)
Domestic Violence Assessment	$300 ($150 per session, requires 2 sessions)
Nursing Assessment	$350 - $50 Deposit to book appointment
Letter	$25
Paperwork (FMLA, Disability)	$35
Medical Records	$0.50 per page after one free copy
No Show	$150-$250
Late Cancellation, without 24 hours notice	$50
Court Appearances & Preparation	$120 Per Hour, Per Provider. A $400 Retainer Fee is required prior to any court related services

Telehealth Policy

I, agree to participate in Telehealth for ongoing treatment performed y a provider at Resilience Counseling Services LLC, who assumes sole responsibility and liability for treatment. By signing this agreement, I authorize electronic transmission of my medical information and/or videoconference session so that it can be viewed live by a provider involved in my mental health care. [Note: the likelihood of this transmission being intercepted by persons other than those in this therapy clinic is extremely small]. I understand that I can withdraw my permission at any time. I understand that if I no longer wish to participate in Telehealth sessions, no action will be taken against me that will cause a delay in my care that I may still pursue in-clinic sessions. I understand that as with any technology, Telehealth does have its limitations. There is no guarantee that Telecommunication will eliminate the need for me to see my therapist in the clinic in person. I understand that medical records of Telehealth sessions will be kept by Resilience Counseling Services LLC.

The potential risk of Telehealth for Mental Health services is that there could be partial or complete failure of the equipment being used which could result in mental health provider's inability to complete mental health services.

• There is no video or voice recording kept of the session

• All existing confidentiality protections apply.

• All existing laws regarding client access to mental health information and copies of mental health records apply.

This check box is required:

☐ I Acknowledge that I have read and understood all of the above Policies and Procedures of Resilience Counseling Services in its entirety and agree to abide by them.

Client or Responsible Party Signature Date

Clinicians's Signature Date