

Hello and Welcome!

These forms were created to introduce you to my practice, as well as my policies and procedures. Please complete the following information to the best of your knowledge so that I can better assist you. If you are unsure of any information, just leave it blank and we can complete it together. Please bring these forms with you to your first appointment, along with your insurance card. Thanks so much for providing this information and I look forward to working with you!

Client Information

Name: _____ Gender: M F
first name middle name last name Date of Birth

Address: _____
street address city state zip

Phone Number: _____
home work cell email

Marital Status: married divorced separated single _____
social security number race/ethnicity

Employment: employed full-time employed part-time unemployed stay-at-home mom / dad student full-time student part-time

_____ employer and/or school attending job title / occupation major area of study

Emergency Contact: _____
phone number relationship to client

Insurance Information

***If using insurance, please bring your insurance card with you to your first appointment!*

Primary Insurance: _____
insurance company name group # policy #

_____ policy holder's name date of birth social security number relationship to client

_____ policy holder's address city state zip phone number

_____ policy holder's employer occupation work phone number

Secondary Insurance: _____
insurance company name group # policy #

_____ policy holder's name date of birth social security number relationship to client

_____ policy holder's address city state zip phone number

_____ policy holder's employer occupation work phone number

Family members living with you:

| <u>Name</u> | <u>Age</u> | <u>Relationship</u> |
|-------------|------------|---------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Reasons for seeking therapy: _____

How did you hear about my practice?

Website _____

Internet Search _____

Friend / Relative's name _____

Doctor's name _____

Other _____

Current Symptoms

(please check severity and all that apply)

| Symptom | Mild | Moderate | Severe | Past | Symptom | Mild | Moderate | Severe | Past |
|--------------------------------------|------|----------|--------|------|-------------------------------|------|----------|--------|------|
| depressed mood | | | | | extreme mood swings | | | | |
| appetite increase/decrease | | | | | frequent irritability / anger | | | | |
| sleep: too much or can't sleep | | | | | periods of nonstop activity | | | | |
| fatigue / low energy | | | | | difficulty concentrating | | | | |
| decreased interest / enjoyment | | | | | inability to complete tasks | | | | |
| emotionality | | | | | impulsive | | | | |
| tearfulness | | | | | easily frustrated | | | | |
| significant weight loss / gain | | | | | physically aggressive | | | | |
| social isolation / withdrawal | | | | | defiance / refusal | | | | |
| sexual dysfunction | | | | | school / work problems | | | | |
| poor hygiene | | | | | anorexia | | | | |
| grief | | | | | binging / purging | | | | |
| guilt | | | | | laxative /diuretic abuse | | | | |
| worthlessness | | | | | excessive exercise | | | | |
| hopelessness | | | | | hallucinations | | | | |
| self harm | | | | | paranoia | | | | |
| suicidal thoughts | | | | | learning disability | | | | |
| suicide attempts | | | | | developmental disability | | | | |
| anxiety | | | | | emotional trauma victim | | | | |
| constant worry | | | | | physical trauma victim | | | | |
| social awkwardness | | | | | sexual trauma victim | | | | |
| panic attacks | | | | | emotional trauma perpetrator | | | | |
| fear people/places/situations/things | | | | | physical trauma perpetrator | | | | |
| frequent head or stomach aches | | | | | sexual trauma perpetrator | | | | |
| muscle tension | | | | | substance / alcohol abuse | | | | |
| easily distracted | | | | | gambling addiction | | | | |
| racing thoughts | | | | | relationship conflict | | | | |
| obsessive thoughts | | | | | infidelity | | | | |
| compulsive behaviors | | | | | other _____ | | | | |

Substance Use History (substance and how often)

Tobacco / Smoking _____ Alcohol _____ Other substance _____ None _____

Gambling / Internet Distress (please describe):

Primary Care Physician: _____ Phone: _____

Medical History

(Please check all that apply)

| | | |
|----------------------|---------------------------|---------------------|
| Asthma _____ | Kidney Disease _____ | Liver Disease _____ |
| Diabetes _____ | Weight Issues _____ | Heart Disease _____ |
| Seizures _____ | Allergies _____ | ADD/ADHD _____ |
| Thyroid issues _____ | High Blood Pressure _____ | Other _____ |
| Cancer _____ | Head Injury _____ | Describe: _____ |

Currently Prescribed Medications:

| Medication | Dosage | Reason for Medication | Prescribing Physician |
|------------|--------|-----------------------|-----------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

*If you need more space, please bring a list of current medications with you to your first appointment.

Injuries or Accidents and when they occurred: _____

Hospitalizations and surgeries (reason for hospitalization and when): _____

Inpatient Psychiatric Hospitalizations (reason for hospitalizations and when): _____

Social

Interests / Hobbies: _____

Religious Affiliations / Spiritual Beliefs: _____

Legal History (arrests, criminal charges, incarcerations): _____

Who would you describe as your 'support system'? _____

Is there anything else you would like me to know about you? _____

Client Rights and Responsibilities

Confidentiality

*Everything shared in therapy sessions and records regarding the therapy process are private and confidential unless you have given signed informed consent. According to Kansas state law, there are exceptions which would require me by law to report with or without consent. These exceptions include:

1. If you threaten to hurt another person, I have a duty to warn the person(s) in danger and to call the authorities.
2. If there is physical or sexual abuse of a child, elderly person or an individual with intellectual challenges, I am mandated by law to report this to the proper authorities.
3. If you are actively suicidal or at risk to hurt yourself, I must seek help for you, including calling the police to check on you or take you to the hospital if warranted.
4. If served a court order, I must appear and / or produce copies of records as directed.

You have the right to report any unethical or exploitive behavior to: Kansas Behavioral Sciences Regulatory Board, 712 S. Kansas Avenue, Topeka, KS 66603.

*If more than one person or family member participates in a session, these other persons are not entitled to your information. However, the therapist cannot guarantee those other persons will abide by confidentiality concerning the session.

*Online billing and administrative software is used for scheduling, billing and record management. Third party billing and collection services may be utilized and administrative personnel may be utilized in order to process billing, insurance claims and keep records. Additionally, there will be communication with insurance companies for benefit and billing purposes. Each of these will come in contact with clients' personal information and all are subject to the same confidentiality rules as stated above.

*In attending trainings or learning with other therapists, part of the learning process includes consulting with other clinicians. Care will be taken to protect identifying client information unless there is a concern for safety or abuse. Additionally, client information may be presented to professional colleagues / therapists for the purpose of case consultation or on-call services. Again, all are subject to the same confidentiality rules as stated above.

Treatment

*You have the right to be treated with respect and dignity and will never be subjected to abuse or exploitation.

*You have the right to participate in developing your treatment plan, including the right to request changes regarding specific services or providers.

*You have the right to end treatment at any time, unless you are court ordered for treatment. However, you are responsible to pay for any treatment you have already received.

*You have the right to receive information regarding your therapist's qualifications, license, education, training, experience, special areas of practice and limits of practice. I hold a Master's degree in social work and am licensed in Kansas as a Licensed Specialist Clinical Social Worker.

*You have the right to receive information on available treatment options and seek out additional opinions concerning your care.

*You have the right to view your records if desired unless it is deemed harmful to your welfare. I request that we review information together so that I may explain clinical language.

* Eye Movement Desensitization and Reprocessing (EMDR) is sometimes used in treatment to alleviate stress associated with traumatic memories (Francine Shapiro). EMDR addresses past trauma, current triggers and future skills and situations and has been found to be effective for many issues. Please be advised that during EMDR, distressing, unresolved memories may surface, high levels of emotion or physical sensations may be experienced and continued processing may occur after the session by way of dreams, flashbacks, feelings, memories, etc. Before starting EMDR treatment, please consider all of the aforementioned information, ask any questions you might have, and obtain additional information as necessary.

Signing below provides consent to receive EMDR treatment if you choose to, and that you acknowledge that you understand the information listed above.

Crisis and After Hours Care

Due to being in session and schedule restrictions, I may often be unable to answer my phone. My telephone has voicemail access 24 hours a day, 7 days a week, which I monitor regularly. If your call is a clinical emergency and you need immediate assistance and I am unavailable immediately, please call 911. You may also contact COMCARE Crisis at 316-660-7500 or you may contact the Suicide & Crisis Lifeline by dialing 988 OR 1-800-273-TALK.

Responsibilities

*To treat others with respect and consideration.

*To call within 24 hours of a scheduled appointment time if you are unable to attend.

*To attend appointments on time.

*To notify the therapist of a change in any of your information, including but not limited to personal information, insurance information, symptoms.

I acknowledge that I understand and will abide by the above Client Rights and Responsibilities.

client signature / signature of parent or legal guardian

date

witness

date

Financial Agreement for Services

By signing this agreement, you agree to and acknowledge each of the following conditions:

- *The information you have provided regarding insurance coverage is accurate. You are responsible for notifying Lee Ann Batt, MS, LSCSW of any changes in name, address, telephone number or insurance coverage.
- *The client (or you, as the client's parent or guardian) are responsible for payment of fees for professional services.
- *If the client is covered by an insurance policy and Lee Ann Batt, MS, LSCSW agrees to bill that insurance company for services rendered to the client, you are responsible for completing any required preauthorization of services and for all applicable copayments, deductibles, co-insurance and non-allowable charges.
- *Payment for any and all required copayments, deductibles, co-insurance and non-allowable charges is required and due at the time the service is delivered.
- *If your insurance company denies, refuses or fails to make payment for the services rendered, you will be notified by telephone or in writing and will be required to make immediate payment of all sums due.
- *Insufficient funds checks will be assessed a charge of \$30.
- *By signing this agreement, you allow Lee Ann Batt, MS, LSCSW to release any and all mental health records necessary for filing insurance claims and collecting fees from your insurance company.
- *If a client misses an appointment without notifying the therapist 24 hours in advance of the scheduled appointment, the appointment is defined as a NO SHOW or LATE CANCELLATION appointment. Clients will be charged a \$100 fee for each appointment that is not cancelled 24 hours prior to the scheduled appointment time. (Please note that communication via texting is a courtesy to clients, and is not always able to be retrieved in a timely way. Therefore, **all notices of appointment cancellation by clients must be done via email or voicemail, NOT via text.**) This fee must be paid before another appointment will be scheduled. If the appointment time with the therapist was scheduled for the same time at regular intervals, the same day and time may not necessarily be reserved in the future following a missed appointment. In order to meet the needs of other clients, therapy services will necessarily discontinue for a client who has missed appointments frequently. *Some payment sources are exempt from this charge. Services will be discontinued for those clients, under the same policy.
- *You have read the fee policy and accept full financial responsibility for this account, including any copayments and fees not covered by insurance, including missed appointment fees.
- *You give Lee Ann Batt, MS, LSCSW permission to keep credit card information that you provide on file.
- * You authorize Lee Ann Batt, MS, LSCSW to charge the credit card you have on file for all charges you incur, including but not limited to co-pays, late fees, account balances.
- *Life Coaching Clients: Sessions, lasting up to 50 minutes, will be payable at \$150, due at the time of service. These sessions are not covered by insurance.
- *Clinical Therapy Clients: 38-52 minute sessions will be billed at a rate of \$200. Initial and 53-75 minute sessions will be billed at a rate of \$275.
- ***Cancellations:** If appointments are cancelled excessively, services may be discontinued due to the need to use that time for other clients.
- ***Reopening:** If a former client requests future services but has an unpaid balance from previous services, payment of the unpaid fee balance is required and a payment plan may be established.
- *Non-payment for services could result in your account being turned over to a collection agency and / or termination of services. The collection agency will assess your costs of collection including related court, legal and / or attorney fees. Services that have been terminated for non-payment will not be re-opened without payment in full of all account balances.
- *If you are involved in any court matters, legal matters and / or any other situations requiring involvement from Lee Ann Batt, MS, LSCSW therapy services, there may be an additional cost incurred for any reports, letters, appearances or consultations by Lee Ann Batt, MS, LSCSW therapy services. These are typically billed at \$250 per hour, depending on services requested.

I understand all of the parts of the above financial agreement and agree to abide by them.

Assignment of Benefits: I authorize medical benefits to be paid directly to the provider, Lee Ann Batt, MS, LSCSW. A copy of this form shall be considered as valid as the original form.

I understand I am responsible for any balance remaining after insurance payments and write-offs.

signature of responsible party

date

witness

date

Notice of Privacy Practices

I acknowledge that I have received or been given an opportunity to read a copy of Lee Ann Batt, MS, LCSW, LLC's Notice of Privacy Practices.

Under HIPPA legislation, you must also give written permission for me to communicate with you through various ways about appointments and other pertinent information involving your therapy. Please indicate your permission below by indicating each means of communication that is acceptable to you. **Place your initials beside each option you approve.**

____ Mail may be sent to my home address.

____ Phone calls may be made to my home. home phone # _____

____ Messages may be left on my home voicemail.

____ Phone calls may be made to my work. work phone # _____

____ Messages may be left on my work voicemail.

____ Phone calls may be made to my cell phone. cell phone # _____

____ Messages may be left on my cell phone voicemail.

____ Text messages may be left on my cell phone.

____ Messages / information may be sent to my email address.

***I understand that if I am consenting to sending and receiving emails and/or texts, they may be considered a part of my client record. I fully understand that there may be a breach of private information exchanged over email and/or text due to an unsecured network or lack of encryption. Emails and/or texts can be intercepted, altered, forwarded or used without authorization.

*Please note that Lee Ann Batt, MS, LCSW will attempt to respond to client's emails and/or texts in a timely manner. However, no guarantees can be made as to when an email and/or text will be read or responded to. Therefore, it should not be used for medical emergencies or time sensitive matters. If an email and/or text has not been responded to within a reasonable time frame, it is the sender's responsibility to follow up to determine the reason it was not responded to. *Emails may be utilized for appointment cancellations, however, texts are often not able to be retrieved in a timely manner and will not be considered for appointment cancellations.

____ Information about appointments and other non-clinical information may be given

To: _____
relationship to client

To: _____
relationship to client

My signature below indicates that I understand my rights to privacy and gives permission to Lee Ann Batt, MS, LCSW or her representative to contact me or others on my behalf through the means of communication identified above. I also hereby acknowledge that a copy of the Notice of Privacy Practices has been made available to me.

client signature / responsible party signature

date

witness

date

Release of Information to Physician OR Waiver of Physician Consult

Per Kansas state law, licensed mental health professionals are required to consult with a client's primary care physician or psychiatrist whenever symptoms of a mental health diagnosis are present. This is to determine if there may be any medical condition or medication that may be causing or contributing to the client's symptoms. The client or parent or legal guardian may consent to such consultation or may waive such consultation. The clinician may provide treatment until the medical consultation is obtained or waived. **I acknowledge that Lee Ann Batt, MS, LSCSW recommends such consultation.**

I authorize Lee Ann Batt, MS, LSCSW to act on the following:

Please check one: Contact my physician named below for the purpose of the consultation described above. (RECOMMENDED)
 I waive my right to have my physician contacted for the purpose of the consultation described above.

| | | |
|---|------------------|-----------------------|
| _____ Physician's Name | _____ Address | _____ Phone Number |
| _____ client signature / responsible party signature | | _____ date |
| _____ witness | | _____ date |

Consent and Authorization for Therapeutic Services

By signing below, you are:

- *Authorizing Lee Ann Batt, MS, LSCSW to provide mental health services.
- *Acknowledging that Lee Ann Batt, MS, LSCSW will provide mental health services in a confidential and professional manner that complies with State and Federal laws and professional standards.
- *Acknowledging that you have been informed that services not covered by your insurance company will be the responsibility of the client (or parent or guardian of client).
- *Acknowledging that you have received a copy of the Client Rights and Responsibilities.
- *Acknowledging that you have signed a copy of the Financial Agreement and understand the terms of this agreement.

Consent and Authorization (must be signed before services can be provided)

Signature: _____ Date: _____
Must be signed by client OR parent or guardian if client is under 18 years of age.

witness _____
date

Thank you for taking the time to complete these forms and please ask if you have any questions regarding the information contained in them or any other questions you might have regarding your therapy or experience here. I look forward to working with you.

-Lee Ann Batt, MS, LSCSW