Hope Counseling Center, PLLC
Therapy Creating Hope

1313 Lyndon Lane Suite 208
Louisville, KY 40222
502-509-3088

AGREEMENT TO COUNSEL:

This agreement is made this _________ day of__________________, __2022__, by and between Hope Counseling Center, PLLC contracted therapist ______________________________, hereinafter referred to as "Therapist", and ____, hereinafter referred to as "Client".

The parties agree as follows:

1. The Therapist shall provide counseling to individuals or groups as relates to personal or family matters. The Therapist shall not offer medical, legal, or psychiatric services, nor shall the Therapist dispense any type of drugs or medications. The Client shall seek services of these types elsewhere as needed.
2. The Therapist shall provide counseling services to the Client on a per session basis, a standard session is 50 minutes.
3. The Client shall pay to the Therapist $______ per counseling session. If client does not provide 24-hour cancellation notice they will be charged a $75 rescheduling fee or full session fee whichever is greater, regardless of if appointment is rescheduled or vacated. Billing may be made by third parties (Kendra Keith Counseling, at this time).
4. The Client gives the Therapist permission to reproduce sessions in writing, or through the use of audio/video recording devices, for use in supervision.
5. All counseling sessions between Therapist and Client shall remain confidential, unless expressly agreed upon in writing. Confidentiality is limited as defined by law which includes, but is not limited to, incidents of abuse, violence, suicide attempts, criminal activity, etc.
6. If the Client requests assistance from therapist in court related matters, a fee will be assessed for letters, records, the Therapist nor his/her notes as part of any legal action.
7. If necessary, the Therapist shall refer the Client to other Therapists, physicians, governmental or private agencies deemed by the Therapist to be in the best interest of the Client and have no agreements with the Therapist or financial rewards.
8. All notes and records will be maintained in a secured file. Records will be maintained for a period of 5 years. After 5 years the originals will be scanned into a pdf.file or entered into electric records management software, and the originals will be shredded.

______________________________________ ______________________________________

Client/Guardian's signature and date Client's signature and date

DISCLOSURE STATEMENT

The mission of Hope Counseling PLLC, is to be a resource for persons who desire to improve their personal wellbeing. The counseling provided by your therapist, is guided by the highest standards of professional ethics which mandate the following disclosures: ensure that clients are adequately informed of the counseling processes, methods, fees, and alternatives; and thereby make informed consent and agreement to engage in a counseling relationship.

INFORMED CONSENT

I agree to the requirements of the items contained in the **Agreement to Counsel** as listed above; and understand the qualification of the Therapist(s) and do hereby acknowledge that I am executing my **Informed Consent** to receive and participate in counseling by them as a Therapist who works within the standards of professional ethics as established by the American Association for Marriage and Family Therapy as a Marriage and Family Therapist, or other associations and laws of professions in therapy such as social work, professional counselors, art therapists, play therapists, etc.

I understand that communication between the Therapist and myself will be noted and kept in a file, and that the confidentiality will be carefully maintained unless I request and authorize release of information. I understand that my files will be maintained for a period of 5 years, at which time they will be scanned and the originals shredded. In the case of release of information to a third party, I understand that a processing fee will be charged. I understand that the law does place limits on confidentiality in cases of actual or potential harm to myself or other persons as well as court ordered testimony.

I understand that I will be required to pay for counseling appointments broken or cancelled without a full 24-hour notice with either the individual Therapist, receptionist, or on the voice mail service. I agree to payment of fees at the time of service, either before or after each session. In the event my insurance does not cover counseling, I agree to pay the balance of my counseling bill.

If a Client files a complaint or lawsuit against a Therapist, that Therapist may disclose relevant client information as part of the defense against the complaint.

Therapist cannot participate in social media relationships with clients.

I realize that my Therapist works in consultation and cooperation with a variety of other disciplines. If I agree to a referral for testing or medical evaluation, I recognize that these professionals are not a in cohorts with the Therapist or Hope Counseling PLLC, and have no obligation or relationship.

I understand that a personal voice mail will be available when I call. A therapist will attempt to return calls within 24 hours, excluding holidays and weekends. The therapist will share their contact information with the client, the office number is 502-509-3088. In an emergency, I understand that a therapist may not always be available. In that event, I will go to the hospital emergency room, or call the 24-hour Crisis and Information Hotline through Seven Counties at 589-4313 (long distance is 1-800-221-0446).

In witness whereof, the parties have executed this agreement at ________________ (city), Kentucky, the date and year first above written and attested to by signature(s) below.

Date ________________________ ____ THERAPIST

____ ____

CLIENT or guardian CLIENT (if multiple clients)

PERSONAL INFORMATION

Name:	DOB:	Email:
Email: May we send confidential info? **Y/N** (email is not considered confidential communication)		
Address:	City/State:	Zip:
Home Phone:	Cell Phone:	May we: Leave a message **Y/N** Text **Y/N**
Insurance Policy#	Insurance Group #	Ins. Company:
Responsible Party:	Guardian Information: (circle one) FULL LIMITED MEDICAL NONE OTHER	Responsible Party Phone:
Responsible Party Address:	City/State:	Zip:
Primary Physician Name/Address:	Physician Phone:	Preferred Hospital:
Credit Card#		Exp: SEC:

EMERGENCY CONTACTS

Name	Relationship	Home Phone	Cell Phone	Work Phone

MEDICAL CONDITIONS

1.	**2.**	**3.**
4.	**5.**	**6.**

MEDICATIONS:

____

____

*****ALLERGIES****____

____

In my capacity as legal representative, I hereby give permission for representatives of Hope Counseling, PLLC, to sign for emergency medical treatment for a licensed medical provider and provide treatment. ____ Initial

Permission to treat and bill insurance ____ Initial

I acknowledge that I have been offered a copy of the privacy policy ____ Initial

Date_______________

____

Signature of Participant or Legal Representative

This notice describes how medical information about you may be used and/or disclosed and how you may get access to information. Please read carefully.

HIPAA Authorization

All information contained in your record is confidential and disclosed only to authorized persons, including public health authorities such as the Department of Public Health and Human Services, Adult Protective Services, HCFA representatives or their designees. Additionally, bi-annual reviews are made by Human Rights and Behavior Intervention Committees (professional committees bound by the standards of confidentiality) to ensure best practices. Participant records are available at all times to you and/or your legal representative with processing time. Written release by you and/or your legal representative must be obtained before another party may review your file.

1. You have the right to have your records treated as confidential information. You also have the right to give written consent before information is released to sources not authorized by law to receive it.
2. If you do not understand this authorization, tell your mental health professional and they will explain it to you.
3. Hope Counseling Center PLLC, upholds the federal regulations that govern the protection and privacy of participant medical records as established by the Privacy rule contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
4. You have a right to cancel this authorization at any time except: to the extent information has already been shared based on this authorization, or to obtain insurance coverage. To cancel this authorization, it must be made in writing to your mental health professional and to your insurance company.
5. If mental health records are subpoenaed by an adverse party, we will assert the psychotherapist-patient privilege on behalf of the patient and will thereafter act according to the wishes of the patient and the patient's attorney, unless we are ordered by a Court or other lawful authority to release records or portions thereof.
6. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from the right to access to your records.
7. Once this information leaves this office, according to the terms of the agreement, we have no control over how it will be used by the recipient. You need to be aware that your information may not be protected by HIPAA at this point.
8. If you believe your rights have been violated, you are encouraged to speak with Sheri Puckett, LMFT (privacy officer) (502)509-3088 and/or other providers where applicable. You or your legal representative may be referred to the agency grievance procedures in order to express concerns or make a formal complaint.

____   ____________________

SIGNATURE OF PARTICIPANT OR LEGAL REPRESENTATIVE   DATE

(if necessary)

INFORMATION RELEASE TO INTERESTED PARTIES:

I, ______________________________________ authorize Hope Counseling PLLC to release a copy of my mental health information to the person(s) or facilities below:

Name: ____________________________________ Phone: _____________________________

Organization: ____

Date of authorization: ________________________ Relationship: ________________________

Termination of authorization (if no date specified authorization will continue until treatment ends): _______________________ or upon the following event occurring: _______________________
____

I authorize the release of my protected health information as described in my directions above. I understand that authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by the laws that limit the use and/or disclosure of my protected health information.

Signed: ____ Date: ___________________________

Grievance and Appeals Form

We hope that you are satisfied with your care, but if you are not, please notify us so that we may address any problems. Any individual needing to file a grievance or complaint while receiving the services Therapist should do so by following the steps listed below:

1. **Direct Service Provider-** A grievance should first be addressed at the direct service level. The individual or advocate for the individual should bring the matter to the attention of the employee contractor of Hope Counseling PLLC with whom the concern is associated directly.
2. **Contact Sheri Puckett, owner** Hope Counseling Center, PLLC at 502-509-3088
3. If you still believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person:
   Compliance Officer: *Sheri Puckett, LMFT*
   Telephone: *(502) 509-3088*
   Address: *1313 Lyndon Ln. Suite 208, Louisville, KY 40222*

You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

4. **Further Legal and Protective Action-** If the individual or advocate for the individual is still not in agreement with the decision, the individual can request that the grievance be heard by the funding source (i.e. Medicaid) by contacting Legal Aid at (502) 584-1254, Protection and Advocacy at (502) 564-2967, or the Kentucky Human Rights Committee.

Other rights

- You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those, which, in our professional judgment, constitute an emergency.
- You can make a written request that we amend the information in your records.
- If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.
- If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.
- You can make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our operations. This can go back as far as six years. A fee may be charged for the tabulating of these disclosures if the request is made more than once in a 12-month period.

PERMISSION TO CONSULT

As a mental health professional, at times it is necessary to collaborate with other professionals to provide the best services to clients. To do that we, at times, collect information from clients while we work with them by taking notes, videoing, audio recordings, or pictures of materials used or produced in sessions. This information allows us to acquire assistance in the professional therapeutic process from other colleagues, other mental health professionals, doctors, supervisors., etc. allowing on-going education of our staff and to provide the most appropriate treatment for our clients. In order to do this, we need your permission to discuss and share case specifics with those listed and others as we see necessary to provide the best services. The person(s) that the information is shared with is under the same privacy obligations as we are to protect your personal information.

Therefore, we are asking you to read and sign the following:

I, the client (or his/her parent/guardian), consent to sharing with professionals in order to treat or provide services of your therapy sessions or materials produced for the purposes described above. This consent is being given in regard to all professionals being provided by Hope Counseling Center, PLLC. I understand that I will not be required to agree to recording and that there will be no negative consequences if I choose to decline a recording request or session.

Signature: ____________________________________ Date: ________________________

Therapist Name: ____
I have discussed this permission with the client and agree my observations of the client gave me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature: ____________________________________ Date: _________________________

Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks:
Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions.
Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:
What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and/or notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. Age of confidentiality in KY is 16.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.
The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

____ ____________________
Client Signature (Client's Parent/Guardian if under 18)   Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be charged $75 or for the entire cost of your scheduled appointment, whichever is greater, if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be billed and charged accordingly with the credit card number on file or an invoice may be sent to collections.

We appreciate your help in keeping the office schedule running timely and efficiently.

____ ____________________
Client Signature (Client's Parent/Guardian if under 18) Date

ADDITIONAL INFORMATION

How would you rate your health? ____

What, if any, health problems are you having at this time? _________________________

Any chronic pain? ____

How are you sleeping? ____

How many times per week do you exercise? ______What types? ____________________

Do you experience any difficulties with eating or your appetite? ____________________

if yes, please explain:____

Are you experiencing any panic attacks, anxiety, phobias? _________________________

if yes, please explain: ____

when did they start? ____

Do you consume alcohol? _____________ If yes, how often? _____________________

MARRIAGE INFORMATION *(if never married, check ______ and omit this section)*

Name of spouse ________________________________ Address _________________________________

Home Phone ____________________ Occupation _______________________ Work Phone ________________

Spouse's age ____________ Education level __________________ Religion _____________________________

Is spouse willing to come to counseling? YES NO UNCERTAIN

Have you ever filed for divorce? YES NO If yes, when ________________ Separated? YES NO ____________

How did previous marriage(s) end, and when ____

Date of this marriage ____________________ Your age when married: husband _________ wife _________

How long did you know one another before dating? _________________ How long did you date before getting engaged? _________________ How long were you engaged before marrying? ______________________________

INFORMATION ABOUT CHILDREN:

NAME	AGE	SEX	LIVING	EDUCATION	MARITAL STATUS

PARENTAL FAMILY HISTORY:

Were you raised by your biological parents? YES NO If no, who raised you, and why _______________________

____

Are your parents living? YES NO If no, when did they die and how ____________________________________

____

Are your parents married? If no, when did they divorce, and have they remarried ___________________________

____

Approximate age when married: Father _________________________ Mother ____________________________

Nationality of parents: Father _________________________ Mother ____________________________

Religious preference: Father _________________________ Mother ____________________________

Education level: Father _________________________ Mother ____________________________

Rate your parents' marriage (circle one): VERY HAPPY HAPPY AVERAGE UNHAPPY

As a child, were you closest to: Father ____ Mother _____ Another ___________________________

Rate your childhood (circle one): VERY HAPPY HAPPY AVERAGE UNHAPPY

List your brothers and sisters in birth order (oldest first) and include yourself:

FIRST NAME SEX AGE LIVING MARITAL STATUS RATE MARRIAGE:

____

____

____

____

Significant losses/deaths of family members, friends or others: ______________________________

____

PREVIOUS COUNSELING: *(if you have not had previous counseling, check ______ and omit this section)*

Please list the name(s) of your previous therapist(s), their contact information, when you saw them, and for what reason(s) you saw them ____

____

What was it about your previous counseling that you found to be helpful ___________________________

____

What was it about your previous counseling that you did not find to be helpful ________________________

____

Have you ever been prescribed psychiatric medications? ________________________________

Outcome? ____

FAMILY HEALTH

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	____________________
Anxiety	yes / no	____________________
Depression	yes / no	____________________
Domestic Violence	yes / no	____________________
Eating Disorders	yes / no	____________________
Obesity	yes / no	____________________
Obsessive Compulsive Behavior	yes / no	____________________
Schizophrenia	yes / no	____________________
Suicide Attempts	yes / no	____________________

ABOUT YOU

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? ______________________________

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: ____________________________________

3. What do you consider to be some of your strengths? ____________________________

____

4. What do you consider to be some of your weaknesses? __________________________

____

5. What would you like to accomplish out of your time in therapy? ____________________

____

____