**COORDINATION OF BENEFITS**

***Primary Insurance:***

Name or Insurance Plan:

Claims Address (Street, City, State, Zip):

Provider Customer Service Phone Number:

Client Name: Client Relationship to Insured:

Client Address (Street, City, State, Zip):

Client Phone Number:

Client Status (Circle all that apply): Single Married Divorced Employed Full-Time Student Part-Time Student

Insured ID # Group #

Insured Name: Insured Birth Date:

Insured Address (Street, City, State, Zip):

Insured Phone Number: Insured Gender (Circle): M F

***Secondary Insurance:***

Name or Insurance Plan:

Claims Address (Street, City, State, Zip):

Provider Customer Service Phone Number:

Client Name: Client Relationship to Insured:

Client Address (Street, City, State, Zip):

Client Phone Number:

Client Status (Circle all that apply): Single Married Divorced Employed

Full-Time Student Part-Time Student

Insured ID # Group #

Insured Name: Insured Birth Date:

Insured Address (Street, City, State, Zip):

Insured Phone Number: Insured Gender (Circle): M F

I, , hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I further expressly agree and acknowledge that my signature on this document authorizes

(“Provider”) to submit claims for benefits, for serviced rendered or for services to be rendered, without obtaining my signature on each and every claim that is submitted, and that I will be bound by this signature as though undersigned had personally signed the particular claim.

I hereby authorize (Insurance Company) to pay and hereby assign directly to Provider all benefits, if any, otherwise payable to me for Behavioral Health Services. I further acknowledge that any insurance benefits, when received by and paid to the Provider will be credited to my account in accordance with the above said assignment.

Client Signature (Parent/Guardian if client is younger than 18 years old) Date

Therapist Signature Date

**INDIVIDUAL CONCERNS**

Name: DOB

|  |  |
| --- | --- |
|  |  |

Check any of the following terms that apply to you (S=Self) or to a family member (F=Family).

S F S F

Depressed Mood Bowel Problems

Lost interest or pleasure Problems Making Decisions

Lack of Energy Problems with Agitation, or Restlessness

Significant Weight Gain/Loss Learning/Academic Problems

Inability to Concentrate Risk-taking Behavior

Excessive Sleeping Feeling Lethargic

Difficulty Sleeping “On the Go” Behavior

Decreased Need for Sleep Impulsive Behaviors

Pressure to Keep Talking Repetitive Behaviors due to Stress

Racing Thoughts Temper

Difficulty Controlling Worry Alcohol Use

Worry about Many Things Drug Use

Panic Attacks Frequent lying/deceitfulness

Excessive fear of situation or Object Problems Following Rules

Aggressive Behavior Toward Others Hear/See Things Others Do Not

Reoccurring Thoughts and Impulses Suicidal Thoughts

Destroying Property Sexual Problems

Witnessed/Experienced an Event Problems Eating

Threatening Life or Serious Injury Nightmares

Significant Ongoing Physical Pain Affair

Stomach Problems Problems with ex/spouse

Headaches Feelings of Hopelessness

Guilt About Many Things Loneliness

Problems with self-worth Insecurity

Isolation Separation

Divorce Parenting Problems

Legal Problems

If you have noticed any recent changes in the following areas, please circle those areas.

*THINKING HEARING BALANCE SPEECH MEMORY ENERGY*

*SLEEPING MENSTRUAL CYCLE EATING SEXUAL ACTIVITY*

List all medications you are taking:

Medication Dosage Prescribed by Date prescription began

Please list any counseling or therapy you or a member of your family are receiving:

Therapist Address When Family Member(s)

**Family Information**

Please list additional family members living with you:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME** | **RELATIONSHIP** | **DATE OF BIRTH** | **WORK/SCHOOL** | **SOC. SEC. #** |
|  |  |  |  |  |
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| --- |
| **INSURANCE PLAN** |
| **ID NO. GROUP NO.** |
| **PROVIDER CUSTOMER SERVICE PHONE NUMBER** |

Have you ever been hospitalized for a mental or nervous problem? No Yes

If yes, when and where?

Have you ever attempted suicide? No Yes

If yes, where, when and how many attempts?

Are you suicidal now? No Yes

Do you drink alcohol? No Yes

If yes, what if your typical drink and how often do you drink alcohol?

Age first used alcohol Age of heaviest/most frequent use Use in last three months

Have you ever been arrested? No Yes

If yes, how many times and for what?

Are you currently involved, or do you expect to be involved in any court-related matters? No Yes If yes, please describe

What important things about your marriage or family would it be helpful for your therapist to know? (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)

Do you have any concerns about violence or abuse in your family? Alcohol or drug usage? Please describe them.

Is there any history of mental health issues in your family? ( depression, suicide, Bipolar Disorder, anxiety, substance abuse)?

**INTAKE INFORMATION**

Client Name Social Security #

Address Birthdate Age

City State Zip Marital Status: Single

Phone home Work Married Since

May we call you at work? Yes No Separated Since

Work Schedule(hours) Divorced Since

Education(years completed) # of previous marriages

Occupation Date of divorce or deaths

Place of Employment

Employment Address Gender: Male Female

Length of Employment Annual Income

Who referred you to Three Rivers? Religious preference

May we thank this person? Yes No

Referral Address

Child/Client Information:

If the Client is a child please answer the following questions:

Child’s Name Social Security #

Birthdate Age Nickname

Child’s address(if different from parent)

School Teacher’s name Phone

Grade currently in Pediatrician

I understand that by signing below I am giving my consent for my child to be seen and am certifying that I am the child’s legal guardian and am authorized to give consent.

Parent/Guardian Signature

**Spouse/Partner Information:**

Client Name Social Security #

Address Birthdate Age

City State Zip Marital Status: Single

Phone home Work # of previous marriages

May we call you at work? Yes No Date of divorce and deaths

Occupation Dates of military service

Place of Employment Annual Income

Length of Employment

Religious Preference

Number of older brothers/sisters Number of younger brothers/sisters

Please describe what your life was like while growing up:

Was your family lower, middle, or upper income/class?

Did your family go to church? Did you grow up in a rural area or city?

EDUCATION:

Years of school completed Highest Degree

Typical Grades Did you receive special education services? Yes No

EMPLOYMENT:

How many places have you worked in the past five years?

Are you currently employed? No Yes If yes, where do you work and how long have you worked there?

If you are not employed, are you:

Looking for work, Retired, Not looking for work

Unable to work (please describe)

SOCIAL AND LEISURE ACTIVITIES:

Please list your favorite leisure activities.

Please list social and community organizations to which you belong.

MILITARY EXPERIENCE:

Did you serve in the Armed Forces? No Yes

PAST AND CURRENT LEGAL INVOLVMENT:

Do you have past legal convictions? No Yes

Are you currently on probation or parole? No Yes

Do you have pending legal charges? No Yes

ADDITIONAL INFORMATION:

Do you have a spiritual or religious belief?

Did you mother have you by natural child birth?

Did she have complications?

How old were you when you crawled? Walked? Said full sentences? Potty trained?

Have you lost a loved one, job, marriage, pet, health, or finances in the last twelve months?

Please describe any additional information you feel is important to know.

**ADULT INFO. FORM**

Name DOB Age

Completed by: Self Other(Name ) Date

**PRESENTING PROBLEMS:**

Please describe the problems for which you are seeking help.

About when did these problems start?

Do these problems seem related to something that’s happened in your life? No Yes

If yes, please describe.

Are there times when these problems seem less or more intense? No Yes If yes, please describe.

**HARM CONCERNS:**

Do you currently have thoughts of harming yourself in any way? No Yes

In the past, did you have thoughts of harming yourself or attempt to harm yourself in any way? No Yes

Do you currently have thoughts of harming someone else in any way? No Yes

Do you have a history of violence towards others? No Yes

Have you ever been emotionally, physically, or sexually abused? No Yes

**SYMPTOMS CHECKLIST:**

Name

Date

*Circle all that apply:*

Anger/Aggressiveness

Anxiety

Appetite Disturbance

Cognitive Impairment

Decreased Energy

Delusions

Depression

Dissociation

Elevated Mood

Fatigue

Hypersomnia

Hallucinations

Hopelessness

Hyperactivity

Grief

Impulsivity

Insight and Judgement Problems

Obsessions and Compulsions

Oppositional Defiant

Memory Problems

Panic Attacks

Paranoia

Poor Concentration

Pressured Speech

Severe Mood Swings

Sleep Disturbance

Body Complaints

Substance Abuse, Past or Present  
Thoughts of hurting yourself or someone else?

**MENTAL HEALTH AND SUBSTANCE ABUSE INFO FOR SELF/FAMILY**

Please list all precious outpatient and inpatient mental health or substance abuse treatment you received.

Name of place Location Dates

Were there things that were especially helpful from any past treatment? No Yes

If yes, please describe

Please list any psychiatric medications you took in the past but aren’t taking now.

Name of Medication Reason Prescribed by Dates

Please list any family history of mental health/substance abuse problems/treatment for grandparents, parents, uncles/aunts, and siblings.

Have friends or family members attempted or committed suicide? No Yes

If yes, please describe

**Alcohol, Drug, and Tobacco Use:**

Do you currently use alcohol? No Yes

Do you currently use street drugs? No Yes

Have you used street drugs in the past? No Yes

Have you use alcohol in the past? No Yes

Do you currently use tobacco? No Yes

Have you used tobacco in the past? No Yes

**Current Medical Information:**

Please list any major physical illnesses or problems:

Please list any drug allergies or adverse reactions to medications:

Who is primary care physician? When and why did you last see your physician?

Please list all prescription medications you are currently taking.

Name of medications Purpose Prescribed by

**Psychosocial History:**

Current living situation:

Marital Status: Single, Married, Live-in, Separated, Divorced,

Widowed

Name of spouse/significant other:

Years married or together:

Number of previous marriages Number of previous live-in relationships

Children/step children:

Name Gender Age Living with you?

**Background Information:**

Please indicate if you were primarily raised by:

Biological mother Biological father

Step mother Step father

Adoptive mother Adoptive father

Foster mother Foster father

Grandmother Grandfather

Aunt Uncle

Other

**CONSENT TO E-COMMUNICATION**

You have a choice about how you communicate with your therapist. Text messaging and e-mail are non-secure forms of communication. This means that these forms of communication are not encrypted and may be accessed by third parties.

It is our policy that therapeutic issues not be discussed at length over text message or email. Discussion regarding therapeutic issues should be limited to scheduled therapy sessions.

Please initial below next to your preference regarding communication with your therapist:

I understand the risk involved with e-mail or text messaging my therapist (that these are non-secure forms of communication) and give my consent to communicate with him or her in the following ways:

Text message (preferred phone number: )

Email (preferred e-mail: )

I do not wish to receive text messaged or e-mails from my therapist. I understand and agree that the therapist will only contact me by telephone (voice call)

Client Signature Date

**PRIVACY NOTICE TO CLIENTS**

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is for your information. Nor response is required.*

The Provider from whom you are receiving mental health services (“The Provider”) is committed to protecting the confidentiality of your health information. This notice describes the ways I which the Provider may use and disclose your protected health information. It also describes your rights and certain obligations the Provider has regarding the use and disclosure of health information. The Provider is required by law to maintain the privacy of your health information, to give you this notice of his or her legal duties and privacy practices, to make a good faith effort to obtain your acknowledgement of receipt of this notice, and to follow the terms of the notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**The following categories describe different ways that The Provider is permitted to use and disclose your protected health information (PHI). To the extent state law requires your consent to these disclosures, The Provider will not make the disclosure without first obtaining your consent. If state law does not require your consent, The Provider is permitted to use and disclose your PHI for these purposes without consent or authorization.

**For Treatment:** The Provider may use and disclose your PHI for treatment purposes. For example, The Provider will obtain information from you related to your treatment and will record such information in your medical record. The Provider may also disclose your PHI to other health care providers who request it in connection with their treatment of you. An example of a disclosure for treatment purposes is a consultation between The Provider and a specialist regarding your condition.

**For Payment:** The Provider may use and disclose PHI so that the treatment and services you receive at his/her offices may be billed to, and payment may be collected from. You, an insurance company or another third party. Examples of such uses and disclosures include, but are not limited to, providing your health plan information about services you received so that it will pay the Provider or reimburse you for the same, notifying your health plan about treatment you are scheduled to receive in order to obtain prior approval for such treatment or to determine whether the plan will cover such treatment, and providing information to third party payers so that they may review the treatment provided to ensure that appropriate care was rendered. We may also disclose your PHI to other health care providers, health care clearing houses and health plans to assist them in their billing and collection efforts.

**For Health Care Operations:** In order to operate an efficient office and ensure that all patients receive quality care, The Provider may use and disclose PHI for various operational purposes. For example, your PHI may be disclosed to members of the medical staff, risk or quality improvement personnel and others to evaluate the performance of staff in caring for you, or to assess the quality of care and outcomes in your case and similar cases, and how to improve facilities and services. The Provider may also disclose your PHI to other health care providers, health care clearing houses and health plans with which you have a had a relationship to assist them with certain of their health care operations activities.

**To Others Involved in Your Healthcare:** The Provider has policies and procedures that provide for the release of information about your care or payment for such care to a member of your family, a relative, a close friend or another person involved in your care or payment for your care when you are not present or able to give authorization for the release of information. If you are present for such a disclosure, (whether in person or on a telephone call), The Provider will either seek your verbal agreement to the disclosure or provide you an opportunity to object to it.

**As Required by Law:** The Provider may use or disclose your PHI to the extent he is required to do so by federal, state, or local law. For example, The Provider may disclose PHI about you for the following purposes: (i) for judicial and administrative proceedings pursuant to legal authority, (ii) to reported information related to victims of abuse, neglect of domestic violence; and (iii) to assist law enforcement officials in their law enforcement duties.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

**Right to Request Restrictions:** You have the right to request The Provider to place restrictions on the way The Provide uses and disclose your PHI for treatment, payment or healthcare operations or as described in the section of this notice entitled “Others involved in your Health care.” You must make your request for restrictions in writing, however. The Provider is not required to agree to these restrictions. If The Provider does agree to the requested restriction, The Provider may not use or disclose your PHI in violation of that restriction, unless it is needed for an emergency.

**Confidential Communications:** You have the right to request The Provider to communicate with you about your PHI by alternative means or to alternative locations. The Provider must accommodate a reasonable request for confidential communications.

**Access to PHI:** You have the right to look at or receive a copy of your PHI contained in a designated record set, with a few exceptions. You do not have the right to look at or receive a copy of any psychotherapy notes in your file. You must make y our request in writing and provide the specific information The Provider needs to fulfill your request. The Provider may deny your request in certain limited circumstances and in some cases, you may have the right to have the denial reviewed by a licensed health care professional who was not involved with the denial of the request.

**Amendment of PHI:** You have the right to request The Provider to amend any PGI about you that is contained in a “designated record set” and which is incomplete or inaccurate. You must make your request for amendment in writing. If The Provider agrees that the original information was incomplete or inaccurate, The Provider will correct his r/her records. If The Provider does not agree, you may submit a short statement of dispute, which The Provider will include in any future disclosure of your PHI or, alternatively, you may request that The Provider provide your request for amendment and the denial of such request with any future disclosures of the PHI at issue. The Provider has the right to prepare a rebuttal to any statement of dispute submitted by you.

**Accounting of Certain Disclosure:** You have the right to request The Provider to provide you with an accounting of certain disclosures he has made of your PHI by making a request in writing. The written request must state the time period desired for the accounting.

**Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice, even if the notice was originally sent to you electronically. You may ask The Provider to give you a copy of this notice at any time. The Provider may change the terms of this notice at any time. The new notice will be effective for all PHI that The Provider maintains, including PHI that was created or received prior to the date of such change. The Provider will make any new Notice of Privacy Practices available at any of The Provider’s healthcare delivery sites whenever The Provider makes a material change in privacy practices described in this notice.

**QUESTIONS AND COMPLAINTS**

For additional information or if you have any questions regarding our privacy policy, please write to the Privacy Officer at Complete Circle Counselor Center; Rebeca Sandoval, LSCSW, LCAC; 127 E Avenue B Suite B; Hutchinson, KS. 67501.

If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your PHI, you may file a compliant with HIPAA Privacy Official at the above address. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. Send your complaint to: Medical Privacy, Complaint Division, Office of Civil Rights United states Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building Washington DC, 20201; or contact the Voice Hotline Number (800) 368-1019; or send the information to their internet address [www.hhs.gove/ocr](http://www.hhs.gove/ocr). The Provider will not take retaliatory actions against you if you file a complaint about The Provider’s privacy practices to The Provider or with the Office for Civil Rights or any other governmental agency.

**For Health and Safety:** The Provider may use or disclose PHI about you if we in good faith, believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health or safety of others. Any Disclosure, however, would only be made to someone reasonably able to help prevent or lessen the threat.

**Correctional Institutions:** The Provider may disclose your PHI about you to a correctional institution or a law enforcement official if you are in their custody provided that the disclosure is necessary for certain purposes, including the provision of your healthcare and the safety and health of others.

**Workers Compensation:** The Provider may use or disclose PHI about you a authorized by laws relating to workers’ compensation or other similar programs.

**Appointment Reminders:** The Provider may use your PHI to provide appointment reminders via telephone (including leaving messages on your answering machine or through the mail (including by postcard). The Provider may also use your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Other Uses and Disclosures of Health Information:** Other uses and disclosures of health information not covered by this notice or laws that apply to The Provider will be made only with your written authorization. You may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on the use or disclosure permitted by the authorization If you revoke your authorization, The Provider will no longer use or disclose health information about you for the reasons covered by your written authorization.

**Signature** **of Client and Date:** **Witness**

**Printed Client’s Name:**

**CLIENTS’ RIGHTS**

1. Clients may prevent the center from disclosing to anyone the fact that they have been previously or are currently receiving any type of mental health treatment. This confidentiality includes anything the client has said provided to the Center staff during any process of consultation, assessment, and/or treatment.
2. The client’s rights or confidentiality shall automatically be claimed on behalf of a client by the Center unless the client expressly waives the privilege in writing. In circumstances where more than one person in a family receives therapy, each such family member who is legally competent to execute a waiver must do so in order for a therapist to disclose information received from any family member.
3. The Center is not obligated to release records that the therapist believes may be injurious to the client.
4. The Center’s staff will not disclose client confidences, as set out above except: (a) as mandated by K.S.A. 38-1552 which includes all cases of suspected child abuse or involvement of a child in a crime in the past or present, (b) as mandated by K.S.A 39-1430 which involves the protection of adults over the age of 18 who are unable to provide this protection for themselves, (c) to prevent a clear and immediate danger to a person or persons, and (d) per order of the court.
5. The Center’s medical consultant and other professional approved supervisors periodically review the client’s progress with the therapist. By signing this form, the client authorizes disclosure of treatment information for supervisory purposes only.
6. Clients are entitled to an explanation of the nature of any course of treatment prescribed, the reason for such treatment, and any know risks associated with such treatment.
7. Clients have the right to refuse any prescribed treatment. In addition, clients must give their written permission to be videotaped or audio taped prior to the therapist doing so.
8. Clients have the right to terminate therapy at any time. Furthermore, the Center’s staff will continue therapy only so long as it is reasonably clear that clients are benefiting from participation in therapy.
9. Should a therapist be unable or unwilling, for appropriate reasons, to provide professional help to a client, the therapist will assist the person to obtain therapeutic service.
10. The Center don’t not discriminate against or refuse professional service to anyone on the bases of race, gender, religion, national origin, or sexual orientation.

*I acknowledge by my signature below that I have read the above information, understand its content, and consent to assessment and/or treatment:*

Client/Parent/Guardian Date

Client/Parent/Guardian Date

Client Date

Client Date

Therapist Date

**FINANCIAL POLICIES**

1. **FEES.** The fees for therapy are as follows: $130.00 per 45-53 minute session; $150.00 per 54-60 minute session; $185.00 per 61-75 minute session and $220.00 per 76-89 minute session. The fee may be adjusted as per contractual agreement with the client’s insurance company, the Crime Victims’ Compensation Board, SRS, or with the therapist. The fee is to be paid at the end of each therapy session.
2. **NO SHOW AND CANCELLATION POLICY.** Notice of cancellation is appreciated 24 hours in advance of a scheduled session so that someone else may be offered the time you cannot take. If you have not cancelled your appointment before the hour you will be charge $65.00. exceptions apply to certain EAPS and Medicaid. The charge must be paid prior to or at the client’s next session. Other exceptions, e.g., due to emergencies, will be made at the discretion of the therapist.
3. **TELEPHONE CALLS.** After-hour telephone calls for other than scheduling purposes may be billed at the established hourly fee. An additional charge of $10.00 will be billed to the client for long distance telephone call made for the purpose of consultation.
4. **COURT.** The client will be charged the rate of $150.00 per hour for the time incurred by the therapist to prepare for and to appear in court or any legal proceeding concerning the client. This will also include travel time. Out of town appearances will be charged a minimum of $500.00 plus any additional time. If court is cancelled less than 24 hours in advance, the client will be charged the time the therapist reserved for court.
5. **REPORTS.** The client will be charged $150.00 per page to prepare written reports for the court or other evaluation purposes. Additional charges may be incurred if excessive review of records and/or collateral contacts are required. The client’s account must be paid in full before the report or evaluation is provided.
6. **RETURNED CHECKS.** The client will be charged a $25.00 administration fee on checks returned due to insufficient funds and will be required to pay cash for any future sessions.
7. **INSURANCE.** Three rivers will file insurance claims for those clients who are eligible for reimbursement. Clients are responsible for providing billing information and a copy of their insurance care. **In addition, clients are responsible for reviewing and knowing their out-patient mental benefits.**
8. **PAYMENTS.** The client is responsible for the payment of amounts not covered by their insurance plan. These amounts can include plan deductible, co-insurance or co-pays, and charges for services not covered by insurance, i.e., court appearances, depositions, reports/evaluation, etc. Please pay deductibles, co-pays or co-insurance at the time of each session.
9. **COLLECTIONS.** All accounts with unpaid balances over 90 days past due will be referred to a collection agency and/or an attorney. A charge of $15.00 and 18% interest on the unpaid balance will be assessed on accounts that are turned over to a collection agency. In addition, attorneys’ fees and courts costs will be added to delinquent accounts that are turned over for collection.
10. **FINANCE CHARGE.** A finance charge of 1.5% per month (18% per year) will be applied to unpaid balances carried over to the next statement.
11. **CONSENT TO BILL.** By the clients signature below, we are authorized to disclose:
12. Confidential diagnostic and treatment information, including medical records, to the client’s insurance company for the purpose of submitting claims on behalf of the client. Furthermore, the Center is authorized to receive any and all payments made by the insurance company directly to the Center and/or to the client for services rendered and chargers submitted; and, (b) The client’s name, address, phone number, and other relevant financial information to a collection agency, attorney, or to the court for the purpose of attaining reimbursement of services provided.

I hereby consent to the fees and policies as set out above. I agree to 1. Use my insurance, 2. Use my EAP sessions, or 3. Pay a self-pay fee in the amount of $70.00/session.

Responsible Party Date

Therapist Date

**INFORMED CONSENT & THERAPY CONTRACT**

*As a client, it is important that you are fully informed about the services you will receive. Your signature below indicates that you have been informed of the policies of this Provider and you are making an informed decision about entering therapy.*

1. I understand that my therapist is an independent Provider licenses in the State of Kansas to diagnose and treat mental disorders.
2. I understand that my provider is bound by the Code of Ethics ser forth by that Provider’s professional association and that I can request a copy of those ethics at any time.
3. I understand that, as a client, I have certain rights and those rights have been reviewed with me by the provider.
4. I understand that, excepts under circumstances mandated by law, communications with Provider will remain confidential as will any records regarding the therapy process unless I sign an Authorization & Request for Release of Confidential Information and Privileged Communication Form authorizing access to the information before any file information will be released in accordance with K.S.S. 65-6410. If more than one family member participates in a session, each and every family member must consent prior to the release of the file information. Where a minor is receiving services, the appointment of a guardian ad litem may be necessary to the release of the minor client’s information. The client’s family members are not entitled access to client information just because they are family.
5. I understand that, in accordance with state regulation and/or professional ethics, specific circumstances require the Provider to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) A Provider believes a client may be and danger to him or herself or to others; b) The Provider believes that a child, elderly, or disabled person may be subject to abuse or neglect; and c) When are court order exists that information regarding the therapy process be provided.
6. I understand that, if the Provider or client records are subpoenaed to court on my behalf, I may be responsible for charges associated with time spent by the Provider to prepare and furnish these records and/or appear in court.
7. I understand that, under Kansas Law, the Provider is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request.
8. I understand that there can be risks and benefits associated with therapy and have discussed those with the Provider.
9. I have read and understand the Technology Policies of the Provider and agree to abide by them.
10. To promote and environment which is safe and free of violence, the possession and/or use of dangerous weapons on site is prohibited. By signing below, you agree that you will abide by this policy.
11. I understand the financial policies or the therapy site and agree to pay $ for each therapy session.
12. I agree that if I need to cancel or reschedule and appointment that I will let the Provider know 24 hours in advance of the appointment, and that if I do not do so, I may be responsible for cancellation fees.
13. I acknowledge that I have received and been given opportunity to review this Providers *Privacy Notice to Clients.*

***My signature below indicates that I give my full and informed consent to receive therapy services from this Provider.***

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature | Date | Client Signature | Date |
| Client Signature | Date | Client Signature | Date |
| Client Signature | Date | Client Signature | Date |
| Therapist Signature | Date | Therapist Signature | Date |

**FAX MESSAGE COVER SHEET**

To: Name:

Company:

Component:

Fax number:

Business phone:

Please notify this person that they have been sent a fax.

**URGENT?**

Yes No

From: Name:

Company:

Department:

Date:

Numbers of pages:

(Including Cover sheet)

Message:

xiohsdgfiohdgjidg

Reply Requested: Yes No

The information contained in this facsimile message may be LEGALLY PRIVILEDGED and is intended only for the individual or entity named above. If you are not the intended recipient, you are hereby notified that any use, review, dissemination, distribution or copying of this document is strictly prohibited. If you have received this document in error, please immediately notify us by telephone and destroy and original message. Thank you!

**WAIVER OF MEDICAL/PSYCHIATRIC CONSULTATION**

|  |  |
| --- | --- |
| Name of Adult Parent | Name of Adult Parent |
| Name of Adult | Name of Adult |
| Name of Minor Child | Name of Minor Child |
| Name of Minor Child | Name of Minor Child |

In the event that I or my minor child(ren) do not have a Primary Care Physician or Psychiatrist, I acknowledge that my Master Level Mental Health Professional has recommended that I seek medical consultation.

By signing below, I am indication that I waive my right to such consultation and that I a

d aware that with waiver will become part of my client record.

|  |  |  |  |
| --- | --- | --- | --- |
| Client Signature | Date | Client Signature | Date |
| Client Signature | Date | Client Signature | Date |
| Client Signature | Date | Client Signature | Date |
| Therapist Signature | Date | Therapist Signature | Date |

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

*The purpose of this form is to authorize (“The Provider”) to share protected information with the identified third party for the purposes of treatment, payment, and health care operations. If you refuse to authorize any such disclosure, complete the box labeled “Restriction on Disclosure.” Otherwise, please complete the form as indicated.*

**CLIENT:**

Last Name First Name MI Date Of Birth

**THIRD PARTY:**

Organization/Individual Name

Address Telephone/Fax

I authorize the Provider to (check all that apply)

Release to Obtain from Discuss with

The third party identified above the specified protected health information listed below for purposes of treatments, payment, and health care operations.~This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding threat the consent will continue to unrevoked until the purpose for which the consent was given shall have been accomplished. However, any consent given under 42 CFR Part 2, Federal Resister, Volume 52-Number 110, June 9, 1987, shall have a duration of no longer than that reasonably necessary to effectuate the purpose for which it is given. Notice to clients: This release form is also compliant with 45 CFR Parts 160 to 164. ~

***PLEASE INITIAL EACH APPLICABLE ITEM:***

Admission Evaluation Report Hospitalization Screening

Diagnosis Only Medical Reports

Treatment Plan(s) Coordination of Care

Psychiatric Consultation Report HIV/AIDS Information

Psychological Evaluation Report Progress Notes from to

Discharge Summary Legal Reports

Progress Review(s) Education Reports

Alcohol and Drug Treatment Information Other:

This authorization shall remain in effect until (date) at which time this authorization expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for one year from the date listed below,

I understand that enrollment, eligibility, payment, or treatment is no conditioned upon the authorization. I understand that fees may be charged for preparing and sending copies of records. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to the Provider.

**~Prohibition on Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.~**

**Print Name and Date: Parent Guardian Print Name and Date:**

**Client Signature and Date: Parent Guardian Signature and Date:**

**Witnessed Signature, Credentials and Date:**