Minor Client Information

Diagnosis Code _____

Client's Name _____ SS# _____

Parent/Guardian Name(s) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Gender _____ Date of Birth _____ Age _____ Grade _____

School

Current School _____ Phone _____

Previous School _____ Phone _____

Health

Who is your child's pediatrician? _____Last visit? _____

Address _____ City _____ State _____ Zip _____

Any concerns shared by the doctor? _____

List all medications your child takes or has taken in the last year _____

_____

Contact in case of emergency _____ Phone _____

List all prior counselors, dates seen and reason for counseling _____

_____

Why are you seeking counseling? _____

How would you rate the intensity of the problem or concern that brought you in? (Circle number):

1	2	3	4	5
Not intense		Moderately intense		Extremely intense

Approximately how long have you had the current problem? _____

How were you referred? _____

Family Status

List all family members living within the household from oldest to youngest (including client):

Name	Age	Relationship

Parents living? Father • Yes • No Mother • Yes • No

• Single • Married • Divorced • Remarried • Widowed

Describe your child's peer relationships _____

_____

_____

Describe your child's performance and behavior at school _____

_____

_____

Describe your child's relationships with family members _____

_____

_____

Are there any pets in the household? If so, what type? _____

_____

_____

How does your child typically deal with anger and frustration? _____

_____

_____

Adult Client Information

Diagnosis Code _____

Client's Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Gender _____ Date of Birth _____ Age _____ Grade _____

Occupation
Employer _____ Phone _____

Address _____ City _____ State _____ Zip _____

Health
Who is your doctor? _____Last visit? _____

Address _____ City _____ State _____ Zip _____

Any concerns shared by the doctor? _____

List all medications you take or have taken in the last year _____
_____

Contact in case of emergency _____ Phone _____

List all prior counselors, dates seen and reason for counseling _____
_____

Why are you seeking counseling? _____

How would you rate the intensity of the problem or concern that brought you in? (Circle number):

1	2	3	4	5
Not intense		Moderately intense		Extremely intense

Approximately how long have you had the current problem? _____

How were you referred? _____

Family Status

List all family members living within the household from oldest to youngest (including client):

Name	Age	Relationship

Marital Status

• Single • Married • Divorced • Remarried • Widowed

If engaged, wedding date? ____/____/____

If married, when? ____/____/____

If divorced, when? ____/____/____

If widowed, when? ____/____/____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the facility, I authorize KMK Counseling LLP to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Physician's Name: _____
Preferred Medical Facility: _____
Insurance Carrier: _____
Designated Person: _____ Phone: _____

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

Date: _____ Consent Signature: _____
Client (parent or guardian if minor client)

Print Name: _____ Phone: _____
Address: _____

NON-CONSENT PLAN

I do not give consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the facility. In the event emergency treatment/aid is required, I wish the following procedures to take place: _____
_____
_____

Date: _____ Non-Consent Signature: _____
Client (parent or guardian if minor client)

Print Name: _____ Phone: _____
Address: _____

Participant Informed Consent and Voluntary Release Form

DISCLOSURE

For KMK Counseling LLP, safety is our number one priority in the facilitation and management of all levels of programming, however, even with adherence to recognized risk management practices in adventure programming and horse-related activities, accidents do occur. The level of participation in our programs is entirely voluntary and under individual choice at all times and for ALL aspects of the programming or training.

KMK Counseling LLP programs and training involve a variety of activities including warm ups, discussion/debriefing,

VOLUNTARY RELEASE OF LIABILITY

I am over 18 years of age. I assume full responsibility for myself and/or my child(ren) for all risks, inherent and otherwise, related to attendance and participation in this program sponsored by KMK Counseling LLP. By signing this release form, I agree to release and hold harmless KMK Counseling LLP, its agents, assistants, employees, facilitators, all individuals assisting in instructing and conducting these activities, and co-sponsors including but not limited to their employees or agents, all shareholders, officers, members or partners (collectively known as Releasees), for any damage or injuries, physical or mental, which I and/or my minor child(ren) might incur as a result of my voluntary decision to participate in this program. By signing this release form, I agree that if I (or my minor child) do(es) sustain any physical injury or mental damage of any nature as a result of my voluntary decision to participate in the program, on behalf of myself, my children, my heirs, my personal representatives and next of kin, I hereby release and discharge Releasees and their successors, assigns, affiliates, directors, officers, employees, members, partners and agents from any and all liabilities, claims, lawsuits, losses, costs, causes of action, and damages of any kind originating in any way arising from my or my children's participation in activities (Even if such claim is due in whole or in part to the negligence of Releasees and their successors, assigns, affiliates, directors, officers, members, partners, employees and agents). The foregoing release includes a release of Releasees and their successors, assigns, affiliates, directors, officers, members, partners, employees and agents for their own negligence. In the event that any of my children, guests, or other third person shall assert any claim whatsoever kind against the Releasees, their successors, assigns, affiliates, directors, officers, members, partners, employees and agents, arising out of or related in whole or in part to any negligent act or omission by me in connection with program activities, I agree to indemnify and hold harmless the Releasees, their successors, assigns, affiliates, directors, officers, members, partners, employees and agents from any such claims and any related liabilities, obligations and expenses, including attorneys fees and other costs of investigation and litigation.

I assume full responsibility for myself and/or my minor child(ren) and guests for bodily injury, death, loss of personal property, and expenses thereof, as a result of my negligence, or other risks, including but not limited to those related to participation in any aspect of this program for the full duration of my participation in this program.

I acknowledge that I have been given the opportunity to ask questions regarding any aspect of this release form and by signing in the space provided do acknowledge that I have read completely and fully understand all aspects of this release form and agree to its terms in their entirety. I have been informed of the full nature of this program and its inherent risks and fully understand the nature of the program.

Date: _____ Consent Signature: _____
Client (parent or guardian if minor client)

Print Name: _____ Phone: _____
Address: _____

MEDICAL INFORMATION

If I and/or my minor children do voluntarily choose to participate in the program or any other activity sponsored by or connected to KMK COUNSELING LLP, I recognize that there is a significant element of risk in any adventure, sport or activity associated with outdoors, which my involve horse-related activities. Knowing the inherent risk, dangers and rigors involved in the activities, I certify that I and/or my minor children are fully capable of participating in the activities.

I disclose the following medical information so that KMK COUNSELING LLP and staff are properly informed. (Please indicate N/A if not applicable)

I am currently under a doctor's care for: _____

_____

I am currently taking the following medication(s) (Please list any side effects which might affect your participation):

_____

I am allergic to the following medication(s) or allergen(s), such as food, insect bites, poison ivy, etc. (Please bring medications for asthma or allergies with dosage marked with you, i.e. inhaler, epinephrine):

_____

The following condition(s) might affect my participation: _____

_____

By signing this release form, I assume full responsibility for all risks, inherent and other, related to my attendance and participation in this program sponsored by KMK COUNSELING LLP as noted in the Voluntary Release of Liability above. I further consent to first aid, emergency care and, if necessary, admission to an accredited hospital for treatment of injuries that I may sustain while participating in any activity associated with KMK COUNSELING LLP.

PLEASE SIGN

_____

Participant Signature Date

_____

Participant Name (print)

_____

Address City Zip

_____

Parent/Guardian (if participant is under 18 years of age)

PARENT OR GUARDIAN AUTHORIZATION

In the event I cannot be reached in an EMERGENCY, I hereby give my consent to hospitalize and or secure treatment for my minor child.

_____

Parent/Guardian Signature Phone

_____

Physician Name Phone

Additionally, I grant to KMK COUNSELING LLP and persons acting for or through them, the rights of use, reproduce, assign and/or distribute photographs, films, videotapes, and sound recordings of myself for use in marketing or education materials they may create. I decline the photo/media release _____ (please check)

Professional Disclosure Statement and Informed Consent

Please Initial Each Item:

_____ The psychotherapy and/or counseling will be conducted by a qualified psychotherapist/counselor.

_____ I understand according to the professional licensing law and professional ethics these professional counselors are qualified to help me be released to experience further interpersonal and intra personal development.

_____ Specific objectives and methods are to be agreed upon in consultation with the therapist. I understand that a non-physician therapist will not prescribe medicine.

_____ The therapist is a consultant and resource professional. His/Her suggestions may be freely accepted or rejected by the client. Therefore, decisions made during and after therapy are the responsibility of the client.

_____ Consultations, test results and disclosures between the counselor and the client will be held in confidence within the restrictions of Texas State law. These exceptions to confidentially include cases in which: (1) illegal activity is occurring (such as physical or sexual abuse); (2) the purpose of counseling is to obtain a court evaluation; or (3) legal action regarding the therapy itself (such as a malpractice suit) is in progress. The counselors are ethically and legally responsible to protect and maintain the counseling relationship while not in conflict with the basic laws of society.

_____ I affirm that I have read all the conditions above and that they have been fully explained to my satisfaction. I understand and agree to them freely and without reservation.

_____ I understand that KMK COUNSELING LLP does not provide 24· hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9·1·1 or go to an emergency room for assistance.

_____ I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship. If at any time I am dissatisfied with the counseling services provided me, I have the right to inform my counselor. If I do not feel that my complaint is resolved, I may file a formal complaint through contact with the Texas Board of Examiners of Licensed Professional Counselors at 1.800.942.5540.

_____ I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and my counselor will not initiate conversation.

_____ Should I believe that a referral is needed, KMK COUNSELING LLP will provide some alternatives including programs and/or people who may be able to assist me.

_____ I understand that all fees for counseling are due after each session.

_____ I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, ARD meetings, classroom observations, legal depositions, interactions with insurance providers, phone calls over 5 minutes, etc. will be billed at $120.00 per hour in 10·minute increments.

_____ I understand that if a check is returned, a processing fee of $25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25.00 processing fee. After a returned check, KMK COUNSELING LLP and persons acting for or through it, may require cash payment of future appointments.

_____ I understand that if a returned check is not cleared up in 30 days, KMK COUNSELING LLP and persons acting for or through it, may file a suit with the Tarrant County District Attorney's Office.

_____ I understand that I am responsible for any appointments that are not canceled at least 24 hours prior to my appointment time, with the exception of an emergency. I understand that if I do not cancel my appointment 24 hours ahead of time, the fee for calling to cancel on the day of my appointment is $120.00.

_____ I understand that if I do not show up for an appointment will result in my being charged $120.00 for the full missed session.

_____ I understand that conducting expert witness/testimonial services is not an area of interest of KMK

COUNSELING LLP and persons acting for or through it, as a factual case witness or involve them in court-related processes, she charges a retainer fee of $1,500.00, with an additional $120.00 every hour she is involved in legal dispositions, in case preparations, travel, and witness time.

_____ I understand that if I do issue KMK COUNSELING LLP and persons acting for or through it a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

_____ I understand that my records and all of our communications become part of the clinical record. Records are the property of KMK COUNSELING LLP and persons acting for or through them. Adult client records are disposed of seven (7) years after the client has stopped receiving services.

_____ I understand that while most of our communication is confidential there are, however, circumstances when disclosure can occur without my prior consent. The following are typical, but not exhaustive, examples of situations and circumstances under which information may be disclosed without prior consent:

- I am a danger to myself or someone else.
- In situations of suspected child, spouse, or elder abuse, it is the duty of the mental health provider to notify medical, legal or other authorities.
- You disclose sexual contact with another mental health professional.
- If you are involved in legal action/proceedings, your records may be subject to subpoena or lawful directive from a court.
- KMK COUNSELING LLP and persons acting for or through it are ordered by a court to disclose information.
- You direct KMK COUNSELING LLP and persons acting for or through it in writing to release your records.
- KMK COUNSELING LLP and persons acting for or through them is otherwise required by law to disclose information.

Statement of Understanding

I have read the above and understand the nature of service providers and Limits of Confidentiality outlined above and I solemnly swear that all of the above information is true to the best of my knowledge.

_____

Client Signature (parent or guardian if minor child) Date

Health Provider's Statement

I have inquired to insure that the patient understood the above description of the limits of confidentiality.

_____

Health Provider's Signature Date

HIPPA Notice of Privacy Practices

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 of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval or admission.

Healthcare Operations: We may use or disclose, as needed, your protected health Information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to graduate students who see clients at our facility. In addition, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself or to others.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or the therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgment of Receipt of HIPPA Notice of Privacy Practices

I acknowledge that I have received and understood the HIPPA Notice of Privacy Practices for KMK COUNSELING LLP.

_____

Client Signature (parent or guardian if minor client) Date

Consent for Use and Disclosure of Health Information:
I hereby permit and release KMK COUNSELING LLP to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment, or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payers, or any organization contracting with any of the above entities to perform such functions.

_____

Client Signature (parent or guardian if minor client) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditioned on your signing this consent.