Kentucky Counseling Associates, LLC

CLIENT DEMOGRAPHIC AND INSURANCE FORM

You may fax forms to our office: 859-759-0970

Client Information:

Client Name: _____ Date: _____
(First) (Middle) (Last)

Gender:_____ Age: _____ Date of Birth:_____ SSN: _____-_____-_____

Address: _____City:_____ State:_____Zip:_____

Home Phone: _____Okay to leave a message? ☐Yes ☐No

Other Phone: _____ ☐Work ☐Cell Okay to leave a message? ☐Yes ☐No

Email address: _____Okay to contact by email? ☐Yes ☐No

Parent/Guardian: _____
Name Relationship Phone

Emergency Contact: _____
Name Relationship Phone

Primary Care Physician's Name: _____ Phone Number: _____

Medicaid Insurance Information:

Name of Managed Care Organization: ☐Aetna Better Health Kentucky ☐Anthem Blue Cross and Blue Shield ☐Humana CareSource ☐Passport ☐WellCare

Medicaid ID Number: _____

Private Insurance Information:

Name of Insurance Company:_____ Member ID:_____

Name of Policy Holder: _____DOB of Policy Holder:____/_____/____ Relationship:___

Self-Pay Clients:

☐ I will pay by check/money order ☐ I will pay by credit card (fill out credit card authorization form at end of packet)

Kentucky Counseling Associates, LLC

Additional Client Information

Please circle any of the following that are currently troubling you or your child:

Alcohol/Drug Use	Eating Problems	Verbal Abuse
Self Esteem	Sexuality	Sexual Abuse
Assertiveness	Suicidal Thoughts	Marriage/Spouse/Partner
Addiction	Depression/Sadness	Loneliness
Appearance/Weight	Anxiety/Panic	Perfectionist
Expressing Feelings	Worry/Fear	Shyness
Grief/Loss	Anger/Rage	Sleep
Meeting People/Friends	Helplessness	LGBT Issues
Guilt	Stalking	Trust
Homesickness	Physical Abuse	Work Stress
PTSD	ADHD	Money/Financial Issues

Other:_____

Please describe your reason for seeking counseling:

Please list any additional information or comments you think are important for us to know:

_____

_____

_____

_____

120 N. Third Street, Danville, KY 40422 • **Phone**: 859-759-1223 • **Fax**: 859-759-0970

INFORMED CONSENT

By signing this form, you agree to participate in mental health services provided by Kentucky Counseling Associates, LLC, and its independent contractors. We know that starting counseling is a big decision and you may have many questions. We will do our best to answer any questions or concerns. This form explains information about KCA policy, State and Federal Laws, and your rights about counseling. All KCA employees and contractors have met the highest level of education, certification, and licensing requirements set forth by Kentucky state law. Counseling practices, philosophy and plan limitations and risks will be discussed with you today.

TREATMENT PROCESS AND DOCUMENTATION

It is the mental health professional's responsibility to keep accurate records including Evaluations, Treatment Plans, and Progress Notes. By signing this document, you are consenting to the Treatment Plan that your provider creates and agree to any goals, objectives, and therapy techniques that may be used in your therapy process.

INSURANCE BILLING

If you plan to use insurance to pay for services, claims will be sent to the insurance company based on information used at the time of service. Sometimes, insurance information may change or may not be up to date. If for any reason, inaccurate information related to deductibles, co-pays, or number of available sessions, etc. is retrieved at the time of service, KCA will bill the client for any additional costs associated with mental health services rendered. Additional services may not be provided until the client's balance is current. If balances remain unpaid for 60 days, client information will be sent to a collection agency.

MISSED APPOINTMENT FEES

Appointments will be cancelled and $25.00 fee will be assessed if client is 15 minutes late without notice. If client cancels appointment without a notice greater than 24 hours, KCA will charge the client $25.00.

COURT FEES

If a staff member of KCA is asked to speak in court or is asked for written documentation for court proceedings or is subpoenaed for a court appearance, the client will be charged an hourly fee of $100 per hour for any work relating to the court case.

SELF PAY

53 minute session are $75.00. I agree to allow KCA to keep a copy of my credit card on file.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Confidential information discussed in session is not discussed with anyone without your written permission except for:

1. Diagnosis and dates of service shared with your insurance company to process your claims
2. Information you tell KCA about physical, sexual or elder abuse; then, by Kentucky State Law, I have to report this to the Kentucky Department of Children and Family Services
3. Where you sign a release of information to have specific information shared
4. If you tell KCA you are in danger of harming yourself or others
5. Information shared with therapist's clinical supervisor if applicable
6. When required by law.

If you need to contact me between counseling sessions please call my office. E-mail, text messages and social networking sites are not confidential and I may not be able to respond. If an emergency situation would happen you can call my office to have a counselor call you. If no call is received within 15 minutes or you can't wait call 911.

Signature (Parent/Guardian must sign if client is a minor) **Date**

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Kentucky Counseling Associates, LLC

Client Email/Text (SMS)/Video Informed Consent

If I choose to use email or text (SMS) to communicate with my therapist or case manager, I understand and consent to the following:

Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Email and texts can be used as evidence in court.
g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

Conditions for the use of email and texts

Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Video recording for case review

Occasionally, a therapist may video record a session in order to discuss it with his/her supervisor for case review for educational and treatment purposes. The video will only be used for this purpose and will then be deleted. If I do not consent to video recording at any time, I can reject this practice in writing and give it to my therapist.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my therapist may impose to communicate with me by email or text. Consent can be withdrawn at any time in writing.

Signature (Parent/Guardian must sign if client is a minor) _____ **Date** _____

Kentucky Counseling Associates, LLC

CLIENT RIGHTS
(Client keeps this copy)

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Kentucky Counseling Associates, LLC

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.

Kentucky Counseling Associates, LLC has been and will always be totally committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Your health information may be used for the purposes of providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Kentucky State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information may be used to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I have read and received a copy of the Notice of Privacy Practices and Client Rights document.

Signature (Parent/Guardian must sign if client is a minor) **Date**

120 N. Third Street, Danville, KY 40422 • **Phone**: 859-759-1223 • **Fax**: 859-759-0970

Kentucky Counseling Associates, LLC

Release of Information

Client Name:_____ **Date of Birth:**_____ **SSN:**_____

Address:_____ **City/State:**_____ **Zip:**_____

Please complete if you want your information to be shared

Kentucky Counseling Associates, LLC and those representing this group has permission to share my private health care information with the following individuals and/or entities:

1._____

2._____

3._____

4._____

The individuals and/or entities listed above also have permission to share private information with **Kentucky Counseling Associates, LLC.**

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to **Kentucky Counseling Associates, LLC**. I understand that a revocation is not valid to the extent that **Kentucky Counseling Associates, LLC** has acted in reliance on such authorization. This authorization expires one year from today.

A copy of this release shall have the same force and effect as the original.

_____

Client Signature (Parent/Guardian must sign if client is a minor) Date

_____

Clinician Signature Credentials Date

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

Kentucky Counseling Associates, LLC

Targeted Case Management Services for Medicaid Recipients only

Kentucky Counseling Associates may provide you or your family with case management services if you choose. We provide case management for children and families for many reasons. If you need support with finding community resources such as housing, utilities, and healthcare, you can benefit from case management. If your child needs help at school, or if your family has an open DCBS case, our case managers will help you through this process.

Case managers can also help with the following services:

- Assist parents in finding community resources such as housing, utilities, and mental and physical healthcare.
- Develop safety plans and aftercare plans with families after inpatient treatment
- Maintain working relationships/communications with DCBS, the court, and other community partners
- Transport clients to visits and appointments as needed
- Attend school meetings as needed
- Provide referrals for mental health services and any other required service for the children and/or family
- Complete all court orders as directed by the court
- Provide Independent Living services to children and adults as needed

I want a case manager_____

I do not want a case manager_____

NOTE: By requesting case management service, I give my written consent to allow KCA contractors to provide services at my child's school and other community resources:

_____

Client signature

_____

Parent/Guardian Signature & Date if client is a minor

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PCP Communication Form

Date _____

Primary Care Office: _____

Primary Care Office Fax Number: _____

This letter is to inform your office that our mutual client:

_____
Name Date of Birth

Is receiving mental health services at **Kentucky Counseling Associates** for:

Diagnosis/ Symptoms_____

KCA Provider & Credentials_____

☐This client is NOT prescribed any medication by KCA at this time.

I give Kentucky Counseling Associates and my PCP, listed above, permission to share my private health information with each other. This consent does not expire until I submit written request to terminate communication.

_____
Client Name

_____
Client/Guardian Signature **Date**

Please contact our office at any time to inquire about treatment or to make a referral.

Kentucky Counseling Associates, LLC

For Self-Pay Clients Only

CONSENT TO STORE AND PROCESS DEBIT/CREDIT CARD FOR OUTSTANDING BALANCES

Cardholder Information:

Name as it appears on card:_____

Billing Street Address:_____ City/State:_____ Zip:_____

Email Address:_____

Phone Number:_____

Credit Card Information:

Debit/Credit Card Type: ☐Visa ☐MasterCard ☐American Express ☐Discover Card ☐Other

Card Number: _____

Expiration Date: Month_____ Year_____

Security Code: _____

Kentucky Counseling Associates, LLC may store and process my credit/debit card to cover any outstanding balances that I may incur.

Cardholder Signature:_____ Date:_____