Kentucky Counseling Associates, LLC

CONSENT FOR SCHOOL-BASED COUNSELING

Client Information:

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

Gender:_____ DOB:_____ SSN: _____-_____-_____

Address: _____City:_____ State:_____Zip:_____

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

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

Parent/Guardian: _____
Name Relationship Phone

INSURANCE INFORMATION

Name of Insurance Company:_____ Member/Medicaid ID:_____

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

INFORMED CONSENT

- By signing this form (verbal consent or in person), you agree to allow your child to participate in mental health services provided by Kentucky Counseling Associates, LLC, and its independent contractors.

- Medicaid insurance will cover 100% of services. If you have private insurance, you will be responsible for any balance insurance does not cover. KCA will work out a rate with you that is suitable for your needs.

- 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 or your child tells KCA about physical, sexual or elder abuse; then, by Kentucky State Law, we 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 or your child tells 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

_____ _____ _____
Signature of Guardian or Printed Name for Verbal Consent | Signature ofSchool Official as Witness | Date/Time

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Additional Client Information

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

From the list above, please write down any symptoms the child/student is currently experiencing:

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

Name of person filling out this form: