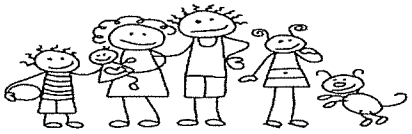
Liberty Family Counseling

816-415-2333 Fax 816-781-1111



Patient Information

Thank you for choosing our office! In order to serve you best, we need you to complete the following information. **Please print**. All information will be kept confidential.

Demographic Information

Date_____ Therapist: ☐ Jeanneen ☐ Pamela ☐ Maureen ☐ Tom

Please check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Patient's Name_____ SSN_____

Gender_____ Race_____ Birthdate_____

Address:_____ City:_____ State:_____ Zip Code:_____

Cell Phone:_____ Home Phone:_____ Email address:_____

Please check the best way to contact you for appointment reminders ☐ Call ☐ Text ☐ Email

Employer name:_____ Work Address:_____ City:_____ State:_____ Zip Code____

Spouse or Parent's Name_____ Phone Number_____

Person to contact in case of emergency:_____ Phone Number_____

Primary Insurance Holder

Name of person responsible for account:_____ Relationship to Patient_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone _____ Cell Phone_____ Birthdate:____/_____/_____

Driver's License #_____ Employer:_____ Work Phone:_____

E-mail address:_____

_____ ____/_____/_____

Patient/ Parent or guardian signature *Date*

Primary Insurance Information

Name of Insured: _____ Relationship to Patient:_____

Birthdate: ___/___/____ SSN:_____ Date employed:_____

Name of employer: _____ Work phone:_____

Address of employer: _____ City:_____ State:_____ Zip:_____

Primary Insurance Name: _____ Policy #_____

Group #_____ Insurance address _____

Your deductible? $_____How much have you used? $_____Max annual Benefit $_____

Do you have additional insurance? ☐Yes ☐NO **If yes, please complete the following:**

Secondary Insurance

Name of insured:_____ Relationship to patient:_____

Birthdate: _____/_____/_____ SSN:_____ Date employed:_____

Name of employer: _____ Work Phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

Secondary Insurance name: _____ Policy# _____

Group # _____ Ins co. Address_____ City:_____ State_____ Zip_____

Your deductible? $_____ How much have you used? $_____ Max annual Benefit: $_____

Authorization

I authorize release of any information concerning my or my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payments of insurance benefits otherwise payable to me directly to the therapist.

I agree to pay in full all outstanding balances at the time work and/or services are completed. I recognize that my failure to pay my account in full within thirty days after work and/ or services are completed may result in my balance being placed with a collection agency and possible listing with the credit bureau(s).

I further agree, in order for you to service my account or to collect any amounts I may owe, your organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of your debt collection agency, may contact me by telephone at any telephone number associated with my account, Including wireless telephone numbers, which could result in charges to me. Your organizations representatives, ancillary provider's, HIPAA business associates, vendors, and the representatives of your debt collection agency may also contact me by sending text messages or emails, using any e-mail address I provide to you. Methods of contact may include using pre-recorded/ artificial voice messages and/ or use of an automatic dialing , as applicable. I have read this disclosure and agree that the Lender/Creditor, and it's ancillary providers, HIPPA Business associates, vendors, and its debt collection agents may contact me as described above

_____ _____/_____/_____

Guarantor/ Customer Signature Date

Patient Intake

How were you referred to our Office?

_____

Family Medical Doctor (first and last name):

_____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____ May we contact you by e-mail if necessary? _____

HISTORY OF PRESENT PROBLEM: Purpose of this appointment:_____

_____

Have you ever had the same or a similar condition? ____ Yes ____ No If yes, when and describe:

_____

_____

PAST HISTORY

Have you ever had: (Place a check mark by conditions that apply to you) __ Anxiety __Eating Disorder __ Depression __ Post Traumatic Stress Disorder __ Anger __ Adoption Issues __ Abandonment __ Other. List: _____ __ Alcoholism __ Other. List: _____ __ Drug Addiction __ HIV Positive Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates):

_____

_____

_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No If yes, describe:

_____

What medications or drugs are you taking? (List name and dosage)

_____

_____

_____

Please list any other health problems you have, no matter how insignificant they may seem:

_____

_____

_____

SOCIAL HISTORY: Do you drink alcoholic beverages?_____ If so, how much per week?_____ Do you use any tobacco products?_____
Do you smoke?____ If so, packs per day: _____ Do you take vitamin supplements?_____ If so, please list:_____ Do you consume caffeine?_____ If so, how much per day:_____ Do you exercise?_____ If yes, what is the frequency and type of exercise?_____
Do you sleep well at night? _____ If no, why not? _____
What are your hobbies?_____
What percentage of time during the day (at home or at your job away from home) do you spend: Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: ____%

FAMILY HISTORY: Parents: Father: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____ Mother: living ___ deceased ____ (check one) Current age if still living:_____ Cause of death and age at death if deceased:_____
Check if applicable to you: ___ I am adopted ___ As an adopted child, little is known of my birth parents or family. Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____
_____
_____

FAMILY DISEASES (if applicable and indicate whether family member is Father, Mother, Sister, Brother): __ Anxiety __Eating Disorder __ Depression __ Post Traumatic Stress Disorder __ Anger __ Adoption Issues __ Abandonment __ Other.
List: _____ Alcoholism __ Other.
List: _____ Drug Addiction __ HIV Positive Please check any and all insurance coverage that may be applicable in this case: ___ Major Medical ___ Sooner Care ___ Medicaid ___ Medicare ___ Medical Savings Account or Flex Plan __ Other
_____

LIBERTY FAMILY COUNSELING INFORMED CONSENT

Please read each one and initial, if you have any questions about anything please ask the therapist to clarify

CONFIDENTIALITY: Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law. _____

WHEN DISCLOSURE IS REQUIRED BY LAW: Disclosure is required or may be required by law when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to me that the you present a danger to others. Disclosure may also be required by the courts. I will not release records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client. _____

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet. _____

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or other third party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier.

_____

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for at least 6 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment. _____

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call us at (816) 415-2333. If we do not answer, we will return your call as soon as possible. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call 911 or go to your nearest emergency room.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for but it takes effort on your part. I want you to be open and honest. We may also talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family,

developmental (adult, child, family), humanistic, play therapy or psychoeducational. I do not prescribe drugs. _____

TREATMENT PLANS: On approximately your second visit, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits. _____

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that case, I will give you a number of referrals whom you can contact. You have the right to terminate therapy at any time. _____

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are unavoidable. I will never publicly acknowledge working with you without written permission. I will not accept you if I feel a significant dual or multiple relationship exists. It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time. _____

SOCIAL NETWORKING AND INTERNET SEARCHES: I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites. _____

I have read the above policies. I understand them and agree to comply with them:

Client's Signature _____ **Date** _____

Therapist's Signature _____ **Date** _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. 1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. 2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law. 3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office. 4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented. 5. Our office may contact you periodically regarding appointments, treatments. 6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. 7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office. 8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change. 9. This notice is effect on the date stated below. 10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

For further information regarding this notice, please contact our therapist at (816) 415-2333 We are pleased to announce that we are offering new services for our appointment reminders.

Liberty Family Counseling 24 hour cancellation policy Liberty Family Counseling has a 24 hour cancellation/rescheduling policy. If you miss your appointment, cancel or change your appointment on the day it is scheduled you will be charged $50.00. This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hour notice can be difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to be seen during that time slot. By signing below, you acknowledge that you have read and understand the cancellation policy for Liberty Family Counseling as described above. Thank you for your understanding and cooperation. Feel free to email the address on your therapist's business card after hours, or call to reschedule or cancel. Please note that the business number 816 415 2333 is only answered Monday through Friday from 8 am to 5 pm.

Printed name _____ Date _____

Signature _____

CREDIT CARD GUARANTEE FOR PERSONAL BALANCES

[ ] UNINSURED PATIENTS Patients who are uninsured or whose insurance does not cover the cost of mental health counseling because of high deductibles or other limitations are personally responsible for payment. Any balance not paid by the end of the week will be automatically charged to your designated card below. This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current.

[ ] INSURANCE ASSIGNMENT Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. On Day 60, if the bill has not been paid by your insurance company, we will charge your designated credit card below for the amount of the claim. Any payments made on these claims thereafter will be immediately refunded to you. I agree to the above terms and authorize you to charge any payment not paid by the end of each week to the above credit card.

SIGNATURE_____ DATE ____/_____/_____

CREDIT CARD: ☐ AMEX ☐ VISA ☐ MC ☐ DISCOVER

CARDHOLDER'S NAME _____

BILLING ADDRESS _____

_____

CARD # _____ EXP. DATE _____

THREE DIGIT CID NUMBER _____

Is this a Health Savings Account? ☐ Yes ☐ NO